Health Office* Unified School District 248
415 North Summit* Girard, KS 66743
phone: 620-724-4076 fax: 620-724-6136

Request for Medication Administration

Name of student: _____
Grade: _____ Teacher: _____

Medication: _____
Dosage: _____ Time of day to be given: _____
Reason for RX: _____
Possible Adverse Reactions: _____
Date prescribed: _____

Signature of Physician or Dentist: _____
(required for prescription medications)

****

I hereby give my permission for _____
to take the above named medication at school.

I understand that any school employee who administers said drug to my child in accordance with written instructions from the physician or dentist shall not be held liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug.

I further understand that with regards to over-the-counter medications, I have consulted a physician in its use and am following his or her advise. I will not hold any school employee liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug.

Date: _____ **Signature of parent or guardian**: _____

Medication is to be brought to school in its original container.
The first dose of medication may not be given at school.