USD 305
Permission for Medication Form

When the administration of medication either prescribed or over-the-counter is required during school hours, the school can provide the service. Kansas law requires written permission from the parent and a signed order from the physician for prescription medication.

Prescription medication: The medication is to be brought to school in the original container appropriately labeled by the pharmacy, or physician, stating the name of the medication, the dosage, and the time to be administered. Ask the pharmacist about an extra bottle for school. The first dose of ANY medication must be given by parent/guardian.

Over-the-counter medication: We require only a parent signature for dosing as recommended. For dosing beyond manufacturer's recommendation a physician signature is required. Please send over-the-counter medication in a small purchased bottle.

Student_____DOB_____Grade_____Weight_____

Reason for RX: _____

Medication:_____ Dosage: _____
generic equivalent may be substituted by pharmacy (prescription) or parent (over the counter medication)

Time(s)/Intervals to administer at school: _____

Date started_____Date to stop_____

Adverse reactions to report to prescribing physician_____

_____

Date_____ _____
(generic equivalent may be substituted by pharmacy or parent, if over the counter medication)
Signature of Physician

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* PLEASE NOTE - A PHYSICAN SIGNATURE IS NOT NEEDED FOR OVER-THE-COUNTER MEDICATION BUT IS REQUIRED FOR PRESCRIPTION MEDICATIONS.

I hereby give my permission for_____to take the above medication at school as ordered. I understand that it is my responsibility to furnish the medication. I further understand that any school employee who administers any drug to my student in accordance with written instructions from the physician or dentist or follows manufacturer's dose recommendations for the OTC medication shall not be liable for damages or adverse effects as a result of administering such drug.

Date_____ _____
(generic equivalent may be substituted by pharmacy or parent, if over the counter medication)
Signature of Parent or Guardian

Date of Approval_____ Approved by_____
Signature of School Nurse

(Rev.2015-16)