

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. **Students who wish to carry emergency medication (asthma inhalers and/or epi pens) must have the back of this form completed as well.**

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 or parent if 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

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 _____
Signature of Parent or Guardian

Date of Approval _____ Approved by _____
Principal or School Nurse

PERMISSION TO CARRY ASTHMA INHALERS/EPIPENS

TO BE COMPLETED BY THE PHYSICIAN: The below-named student has been instructed in the proper use of their asthma inhaler/emergency medication. The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler/emergency medication at school. He/she understands the purpose, appropriate method, and frequency of use of the asthma inhaler/emergency medication.

Student Name: _____

Name Of Medication: _____

Physician's Signature: _____ DATE: _____

TO BE COMPLETED BY THE PARENT/GUARDIAN: I permit my child to carry the above-listed asthma inhaler/emergency medication as ordered by his/her physician.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY SCHOOL NURSE: Kansas law now permits students to carry and use inhaled medications after demonstrating appropriate use to school nurse. This student demonstrates knowledge / skill to carry and use the above listed asthma inhaler.

School Nurse Signature: _____ Date: _____

TO BE COMPLETED BY STUDENT: I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician.

Student's Signature: _____ Date: _____