United School District #347
Kinsley-Offerle
120 W 8th St. Kinsley, KS 67547
Phone 620-659-3646

REQUEST FOR MEDICATION TO BE ADMINISTERED AT SCHOOL

NAME OF STUDENT_____ DATE OF BIRTH_____
SCHOOL_____ GRADE/TEACHER_____

( ) EMERGENCY MEDICATION ONLY: *Student may carry inhaler/emergency medication (asthma, severe allergic reaction, diabetes management) with them. This student has been instructed in the proper use and storage of this medication and has the ability to use the medication as prescribed. Any other medication prescribed is considered non-emergent and must be left in the nurse's office or front office.*

Medication #1_____ Dose_____ Time to be given_____
Medication #2_____ Dose _____ Time to be given_____
Medication #3_____ Dose_____ Time to be given_____
Anticipated number of days to be administered at school:_____Special instructions
_____
Printed Name of Licensed Health Care Provider_____ Signature_____
Address_____ Telephone_____Fax _____
Date_____
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PARENT PERMISSION TO ADMINISTER MEDICATION/ INFORMATION EXCHANGE

I hereby give my permission for my child to take the above prescribed medication at school as ordered by our primary care provider. I understand that it is my responsibility to furnish the medication in the original container appropriately labeled by the pharmacy / manufacturer or physician stating the name of the medication, the dosage, and the number of days to be administered at school. Any school employee who administered the medication in accordance with written instructions from the prescribing healthcare provider shall not be liable for damages as a result of any adverse drug reaction suffered by the student. I also give permission for the exchange of information between the school nurse / other school representative and _____ / pharmacy in the event a question or concern may arise.

( ) EMERGENCY MEDICATION ONLY: My child may carry inhaler/emergency medication (asthma, severe allergic reaction, diabetes management) with them. He /she have been instructed in the proper use and storage of this medication and have the ability to use the medication as prescribed. Any other medication prescribed is considered non-emergent and must be left in the nurse's office.
Printed Name of Parent/ Guardian _____ Signature_____
Address_____Telephone_____ Email_____
Date_____
RETURN THE COMPLETED FORM TO YOUR CHILD'S SCHOOL NURSE OR FRONT OFFICE