KIOWA COUNTY SCHOOLS, USD 422

School Year _____

Request for **Non-Prescription Medication** to be administered during school attendance.

Name of Student _____Birthdate _____

School _____Grade_____

Name of Medication _____Purpose of Medication_____

Prescribed dosage _____ Date Medication Started _____

Time Medication is to be given _____ Expected duration of treatment _____

Any special circumstances under which medication is to be administered?

_____

PARENT REQUEST to administer Medication at School.

I hereby request for the School Nurse, or Designee, to administer the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any drug or nonprescription medication pursuant to parental written request to my student in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse medication reaction suffered by the student because of administering such medication.

Date_____ _____

Signature of Parent or Guardian

_____

Phone Address

NOTE: The medication is to be brought to school in the original container, appropriately labeled with students name, name of Medication, the dosage and number of days to be administered at school. Medication out of a bottle, box, etc. without this label cannot be given.