KIOWA COUNTY SCHOOLS, USD 422

School Year _________

Request for **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 ____________

Date________________ _______________________________________

Physicians Signature

____

Phone Address

PARENT REQUEST to administer Medication at School.

I hereby request for the School Nurse, or Designee, to administer this medication as directed during the hours my child is in school in order to comply with the doctor's orders. 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

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Phone Address

NOTE: Any Prescription Medication sent to school to be administered by the School Nurse or Designee MUST be accompanied by a signed parental consent form and a doctor's written order stating the student's name, dosage, how and when the medicine is to be given, and MUST have the doctor's signature to be valid. It MUST be in the original container with the pharmacist's label, stating the patient's and the doctor's name, dosage and instructions. Medication out of a bottle, box, etc. without this label cannot be given.