KIOWA COUNTY SCHOOLS U.S.D. 422

Request for **Medication** to be **Self-Administered**

During School Attendance/School Year of_____

Student_____Birthdate_____

School_____Grade_____

Name of Medication_____**Purpose**_____

Prescribed Dosage_____ Date Medication Started_____

Frequency med may be taken _____

Time med is to be taken _____

Conditions under which med is to be taken_____

_____

Expected duration of treatment _____

Physician's Signature_____**Date**_____

Phyician'sPhone_____Address_____

I hereby give my permission for my student to take 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 non-prescription medication with written instructions from the physician or dentist shall not be held liable for damages as a result of an adverse medication reaction suffered by the student because of administering such medication. I also state that this child has been instructed on the self-administration of this medication, will store it in an appropriate manner, agrees never to share a medication and is authorized to self-administer at school.

Parent's Signature_____**Date**_____

Parent's Phone_____Address_____

Note: Any Prescription Medication sent to school to be self-administered **MUST** be accompanied by a **signed** parental consent form and a **signed** doctor's written order stating the student's name, dosage, how, and when the medicine is to be taken. It must be in the **original container** with the **pharmacist's label** stating the patient's and doctor's names, the dosage, instructions, and current expiration date. Medication not in the original container without this label cannot be taken. Created on 08/20/2020.