

USD 377 ATCHISON COUNTY COMMUNITY SCHOOLS
REQUEST FOR MEDICATION TO BE ADMINISTERED

MEDICATION TO BE ADMINISTERED DURING SCHOOL ATTENDANCE

Name of Student: _____ Birth Date: _____

School: _____ Grade: _____

Medication: _____

Dosage: _____

Date Medication Started: _____

Reason for Medication: _____

Time of day medication is to be given: _____

Other Special Concerns (Possible Side Effects): _____

Anticipated number of days medication to be administered at school: _____

Date: _____

Signature of Physician

I hereby give my permission for _____ to take the above prescription 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 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 drug reaction suffered by the student because of administering such drug.

Date: _____

Signature of Parent/Guardian

Printed Name of Parent/Guardian

NOTE: The medication is to be brought to school in the original container appropriately labeled by the pharmacy, or physician, state the name of medication, the dosage and number of days to be administered at school.