USD 252--------SOUTHERN LYON COUNTY SCHOOLS

REQUEST FOR MEDICATION TO BE ADMINISTERED DURING SCHOOL ATTENDANCE

NAME OF STUDENT:_____

MEDICATION:_____ DOSAGE:_____

DATE MEDICATION STARTED:_____ REASON FOR RX:_____

TIME OF DAY MEDICATION TO BE GIVEN:_____

IF MEDICATION IS AN INHALER/EPI-PEN – MAY THE STUDENT CARRY MEDICATION: YES NO

DATE_____ _____

SIGNATURE OF PHYSICIAN

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

PARENTS:
I herby give my permission for my child 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 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

HARTFORD JR./SR. HIGH	NEOSHO RAPIDS ELEMENTARY	OLPE ELEMENTARY	OLPE JR./SR. HIGH
Fax: 620-392-5962	620-341-9464	620-475-3951	620-475-3951
Phone: 620-392-5515	620-342-7783	620-475-3277	620-465-3223