Unified School District No. 444
Little River-Windom

455 Prairie Avenue
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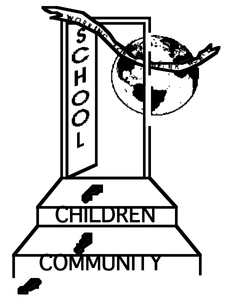
Little River, Kansas 67457
(620) 897-6325
www.usd444.com

Brent Garrison, Superintendent
Randy Hendrickson, Principal
Jon Paden, Principal

EXCELLENCE
THROUGH
EDUCATION



PERMISSION FOR MEDICATION ADMINISTRATION AT SCHOOL

NAME OF STUDENT:____
GRADE:_________________

NAME OF MED	DOSAGE	TIME TO BE GIVEN	PURPOSE

For <u>inhaled</u> medications, please check one of the following:
_____I have instructed the above named student in the proper way to use his/her medication. It is my professional opinion that this student should be allowed to carry the above prescribed medication and self-administer as prescribed.
_____It is my professional opinion that the above names student should not be allowed to carry his/her medication by himself/herself.

Comments/Special
Instructions:____
____
____

Physician Signature____Date___________________

- I hereby give my permission for _______________________ to take the above prescription at school as ordered.
- I certify that the child named above has received at least one dose of the medication requested and has not had adverse reactions to it.
- I understand that any school employee who administers the drug to my child in accordance with written instruction from the physician or dentist shall not be liable for damages as a result of an adverse reaction to the drug.
- I understand that it is my responsibility to furnish this medication.
- I authorize appropriate USD 444 personnel to exchange information regarding this medication request with the healthcare provider listed and with the dispensing pharmacy identified on the medication label.

Parent/Guardian
Signature____Date____________________

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