Mid-Buchanan R-V School District
FAX: 816-238-2484

Long-term medication may be given by district personnel provided that the prescribing physician completes this district medication permission request for:

Student's Name: _____ School: _____ Date of Birth: _____

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN

_____

Physician's Name Address Telephone

Name of Medicine: _____Dosage: _____ Form: _____

Diagnosis for which medication is to be given: _____

If medication is to be given daily, at what time? _____

If medication is to be given, "When Needed", describe indications: _____

_____

How soon can it be repeated? _____

Is the student authorized to carry and/or administer medication or bronchodilators to him/herself?

_____YES _____ NO

List significant side effects: _____

Length of time this treatment is recommended: _____

Other Information: _____

Medications for emergency health conditions must with complete instructions for administering the medication.

Date: _____ Physician Signature: _____

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THE FOLLOWING IS TO BE COMPLETED BY THE PARENT

I hereby give permission for _____ to take the above prescription and/or medication at school as ordered. I understand that it is my responsibility to furnish the medication. I further understand that the above information will be completed by the attending physician or dentist before any medication will be administered, and the medicine will be administered in accordance to their written instructions.

Date: _____ Signature of Parent/Guardian:_____

NOTE: The medication is to be brought to the school in the prescription container appropriately labeled by the pharmacy or physician, stating name of medication, the dosage, time to be administered and the name of the student.