Permission Form for Prescribed Medication

Nurse's Office

12913 Mission Valley Road, Eskridge, KS 66423 **Email:** jmarcotte@mv330.org **Phone:** 866-557-6686 **Fax:** 785-409-6216

Student Name: ________________________________DOB:_______ Grad Year: ____________

To be completed by the physician or authorized prescriber

Diagnosis/Reason for medication: ____

Name of medication: ____

Dosage/Amount/Route/Time: ____

Start Date: ______________ Stop Date: ________________ ( ) For episodic/emergency events only

Desired Benefits of Medication: ____

Possible Side Effects:

____

____

Medication must be in the original pharmacy labeled container.

Date: __________ Physician Signature: ____

Physician's Name & Address: ____

Phone Number/Fax Number: ____

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize the school and the employees and agents, in my behalf and stead, to administer or attempt to administer to my child, lawfully prescribed medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE OR HEALTH AIDE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. The nursing office staff and/or the school administration may, at their discretion, reject requests for administration of medication. It is understood the school district provides this service in the interest of the well being of students and as an accommodation to parents. In addition, I agree to hold harmless and indemnify that School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

To be completed by parent/guardian

I give permission for (name of child) ______________________________ to receive the above medication at school according to standard school policy as noted above.

Date: ___________ Signature: ____________________________________ Relationship: _____________