TEACHING, LEARNING, CARING SINCE 1889

Hesston Unified School District 460

150 N. Ridge Road Box 2000 Hesston, Kansas 67062 620-327-4931 Fax 620-327-7157 www.hesstonschools.org

REQUEST FOR MEDICATION TO BE ADMINISTERED AT SCHOOL

District policy requires that a written request from the parent/guardian accompany all medication that is to be administered by school personnel, including over-the-counter drugs. **All medication must be sent with its name, dosage, time of day to be given, and the prescribing physician's name, if applicable.**

For your child's well being, it is recommended that the medication:

- be administered at home prior to being given at school to avoid unexpected reaction; and
- be sent in the original container.

To Be Completed By Parent:

Student: _____ Age: _____ Grade: _____

Medication #1: _____ Dosage: _____ Time: _____

Medication #2: _____ Dosage: _____ Time: _____

Medication #3: _____ Dosage: _____ Time: _____

Prescribing Physician: _____

Further instructions or reactions to watch for:

_____

_____

Allergies: _____

Parent Statement of Consent/Release:

I hereby give my permission for my child, named above, to take the above noted medication at school as ordered. I understand that it is my responsibility to furnish the medication (as described above) and that any school employee who administers medication to my child in accordance with these written instructions shall not be liable for damages as a result of any adverse drug reaction suffered by the student because of administering such medication. I also give permission for the exchange of information between the school nurse, or other school representative, and the prescribing physician/pharmacy.

_____ _____

Signature of Parent Date