Request for Medication Administration at School

CIRCLE USD 375
District Office: 316-536-2577
District Fax: 316-536-2249

According to Guidelines for Medication Administration in Kansas Schools, when possible, medication should be administered at home using a schedule that will **not** require doses during school hours.

Prescription medication: Medication must be sent to school by the parent/guardian in the original pharmacy container with the pharmacy label affixed. The label must contain the students name, name of medication, dosage/directions, administration time, date, and the physician's name.

Over-the-counter medication: Medication must be sent to school by the parent/guardian in the original container marked with the students name. Age/weight-appropriate bottle instructions will be followed unless a physician provides alternative instructions.

Name of Student_____**DOB**_____

School_____**Teacher**_____**Grade**_____**Start Date**_____

MEDICATION_____

DOSAGE_____

ROUTE: Oral Inhaled Topical Intramuscular Ear Eye Rectal Other:_____

ADMINISTRATION TIME_____

DURATION OF ORDER_____**This request expires at the end of the school year.**

REASON FOR MEDICATION_____

SPECIAL INSTRUCTIONS_____

_____	_____	_____
Printed name of Physician	**Physician Signature**	**Date**

I hereby certify that_____has previously had at least 1 dose of the above prescribed medication and did not have an adverse reaction from it. Therefore, I give permission for my child to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication in a properly labeled container.

I further understand that any delegated school employee who administers any drugs to my child in accordance with written instructions from the physician shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug.

It is the lawful custodian's responsibility to assure that the medication and dosage in the container is the same as is described by the label.

Date: _____Parent/Guardian Signature:_____

***See reverse for Inhaler Release**

Self-Administration of Asthma Medication

(Inhaler Release)

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Name of Student_____**DOB**_____

School_____**Teacher**_____**Grade**_____**Start Date**_____

MEDICATION_____

DOSAGE_____**ROUTE**_____

ADMINISTRATION TIME_____

DURATION OF ORDER_____**This request expires at the end of the school year.**

REASON FOR MEDICATION_____

SPECIAL INSTRUCTIONS_____

***Please attach the students Asthma Action Plan to this form.**

The student has been instructed in and understands the purpose and appropriate method and frequency of use of the inhaler. We request that he/she be permitted to carry the inhaler on his/her person. We, the undersigned, absolve the school of any responsibility in safeguarding the student's inhaler. Inappropriate use of the inhaler may result in disciplinary action.

_____	_____	_____
Printed name of Physician	**Physician Signature**	**Date**
_____	_____	_____
Printed name of Parent	**Parent Signature**	**Date**

Note: It is strongly recommended that each student leave an extra inhaler in the school office in the event of a misplaced inhaler.