

USD 208 – Trego County Schools

REQUEST FOR PRESCRIPTION MEDICATION ADMINISTRATION AT SCHOOL

NAME OF STUDENT _____ DATE OF BIRTH _____

SCHOOL _____ GRADE / TEACHER _____

PHYSICIAN DIAGNOSIS / REASON FOR MEDICATION _____

MEDICATION _____ DOSE _____ TIME TO BE GIVEN _____

Anticipated number of days to be administered at school: _____ Special instructions: _____

Printed Name of Physician _____ * Physician Signature _____

Address _____ Telephone _____ Fax _____

Date _____ **Or a copy of the prescription or fax from health care provider.*

PARENT PERMISSION TO ADMINISTER MEDICATION / INFORMATION EXCHANGE

I hereby give my permission for my child to take the above prescribed medication at school as ordered by our primary care provider. **I understand that it is my responsibility to furnish the medication in the original container appropriately labeled by the pharmacy / manufacturer or physician stating the name of the medication, the dosage, and the number of days to be administered at school.** Any school employee who administers the medication in accordance with written instructions from the prescribing health care provider shall not be liable for damages as a result of any adverse drug reaction suffered by the student. I also give permission for the exchange of information between the school nurse or other school representative and pharmacy in the event a question or concern may arise.

Printed Name of Parent / Guardian _____ Signature _____

Address _____ Telephone _____ Email _____

Date _____

Please Return Completed Form To:
Mandie Kinderknecht RN, School Nurse
612 Junction Ave.
WaKeeney, KS 67672
Fax # - 785-743-5244