USD 357
BELLE PLAINE, KANSAS
ANNUAL STUDENT MEDICATION ORDER/RELEASE
SCHOOL YEAR_____ - _____

TO BE COMPLETED BY PHYSICIAN

_____ _____ _____
Name of student to receive medication age grade

Name of Medication:_____

Specific dose & time:_____

Reason for Medication:_____

Any other pertinent information:_____

_____

Requested start date:_____ Duration/Stop Date:_____

Medication is to be taken to school sponsored events/activities YES____ NO____

Inhaler Use:
Keep inhaler in Health Room only YES____ NO____
Student's to take inhaler to events/activities YES____ NO____
Student is to carry inhaler at all times YES____ NO____

_____ _____
Signature of physician Physician name printed

_____ _____
Date Phone #

TO BE COMPLETED BY PARENT/GUARDIAN:

I hereby give my permission for_____ to take the above prescribed medication at school as ordered. I understand that it is my responsibility to supply this medication. This student has received at least one dose of the prescribed medication in my presence and has not suffered any adverse reactions from this medication. I further understand that the school employee who administers this medication to my child in accordance with written instructions from the physician shall not be liable for damages as a result of an adverse reaction suffered by the student.

_____ _____
Signature of Parent/Guardian Home Phone #

_____ _____
Print Name Work Phone #

Please return this information sheet with the medication to the Office of the School in which your child is enrolled, or to the School Nurse. School Phone Numbers: Elementary-488-2617, Middle 488-2222, High 488-2421, District Office 488-2288. *Summer months contact the District Office at 488-2288.* 8/06