USD 443 – DODGE CITY PUBLIC SCHOOLS PERMISSION FOR ADMINISTRATION OF MEDICATION

(Revised June 2015)

Name of Student ____ Grade ____________

Building ____ Teacher ______________________

Diagnosis ____

Medication ____

Dosage ____

Time(s) to be given ____

Duration of Orders ____

*USD 443 will require a current medical authorization from the medical provider at the start of each new school year. School Nurses reserve the right to request additional information from a physician.

If medication prescribed is for EpiPen, Rescue Inhaler, and/or Diabetic Management – student has demonstrated to health care provider/designee skill level necessary to self-administer

___________Yes ___________ No

Date_________________ Signature of Physician _____________________________________

Office Address ____

Office Telephone Number ____

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I hereby give my permission for ______________________________to take the above prescribed medication at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any medication to my student in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse reaction suffered by the student because of administering such medication. I am requesting the cooperation of school personnel in this matter.

______________________ ____________________________________

Date Signature of Parent or Guardian

NOTE TO PARENT/GUARDIAN: The medication is to be brought to school in the original container appropriately labeled by the pharmacy or physician stating the name of the medication, the dosage, and time to be administered. It is suggested that medication be administered outside of the school day whenever possible.