Unified School District 232
De Soto – Shawnee – Lenexa – Olathe

Medication Form

Permission to administer PRESCRIPTION medications during school attendance

COMPLETED by **HEALTH CARE PROVIDER**:

Student: _____ Grade: _____

Medication:_____ Dosage:_____ Date of Initial Dosage:_____

Reason for Rx:_____

Instructions for Administration: _____

Time of day Rx to be given: ☐After Lunch ☐As Needed ☐Other Time:_____

Anticipated duration of Rx at school: ☐ School Year ☐Other:_____

PRINTED name of prescribing physician: _____

_____

Health Care Provider Signature (REQUIRED) **Date**

COMPLETED by **PARENT / GUARDIAN**

Checklist must be complete!

- ☐ Primary Care Provider section fully completed
- ☐ Prescription Medication is:
  - ☐ In the ORIGINAL container
  - ☐ MUST CONTAIN A PHARMACY LABEL with:
    - ✓ Name of student
    - ✓ Name of medication
    - ✓ Dose & time to be administered
    - ✓ Number of days to be administered
    - ✓ Current prescription date
- ☐ If student will carry & self-administer medication for the treatment of anaphylaxis or asthma (ex: inhaler, Epi-Pen, Auvi-Q) the form ***Permission for Self-Administration of Medication*** must **ALSO** be completed and signed by the Health Care Provider

I understand that any school employee who administers any of the above medications, in accordance with the prescription and/or over the counter directions, to my student shall not be liable for damages as a result of an adverse reaction suffered by the student due to this administration. I further acknowledge that the above student has taken the medication(s) previously (or the initial dosage) and has experienced no adverse reactions

_____

Parent/Guardian Signature (Required) **Date**

Updated 5/8/2024

USD 232
Unified School District No. 232
www.usd232.org

Medication Form

Permission to administer NON-PRESCRIPTION medications during school attendance

COMPLETED by **PARENT / GUARDIAN**:

Student: _____ Grade: _____

I give my permission for school personnel to administer over the counter medication (s) to the above name student for minor discomforts and injuries.

Please check YES or NO for all of the following:

☐ YES	☐ NO	Antibiotic ointment	☐ YES	☐ NO	Ibuprofen (generic for Advil, Motrin)
☐ YES	☐ NO	Hydrocortisone cream	☐ YES	☐ NO	Acetaminophen (generic for Tylenol)
☐ YES	☐ NO	Antiseptic cleanser	☐ YES	☐ NO	Cough drops
☐ YES	☐ NO	Antacid (generic for Tums)	☐ YES	☐ NO	Eye drops (non-medicated)

COMPLETED by **PARENT / GUARDIAN**:

Permission to administer NON-prescription medications during school attendance, other than those listed above:

If a student brings any medication from home it must be in the ORIGINAL container, labeled with the student's name and accompanied by this permission form signed by the parent/guardian

Medication:_____ Dosage:_____ Date of Initial Dosage:_____

Reason for Medication: _____

Instructions for Administration: _____

Time of day Rx to be given: ☐ After Lunch ☐ As Needed ☐ Other Time:_____

Anticipated duration of Rx at school: ☐ School Year ☐ Other:_____

PRINTED name of Parent / Guardian: _____

I understand that any school employee who administers any of the above medications, in accordance with the prescription and/or over the counter directions, to my student shall not be liable for damages as a result of an adverse reaction suffered by the student due to this administration. I further acknowledge that the above student has taken the medication(s) previously (or the initial dosage) and has experienced no adverse reactions

_____

Parent/Guardian Signature (Required) **Date**