Emporia
PUBLIC SCHOOLS

EMPORIA USD 253, Emporia, Kansas 66801

Request for Prescription Medication to be Administered at School

Name of Student _____ Date of Birth _____

School _____ Grade & Teacher _____

Physician Diagnosis/Reason for Medication _____

☐ Emergency Medication Only: Student may carry inhaler/emergency medication (asthma, severe allergic reaction, diabetes managements) with him/her. This student has been instructed in the proper use and storage of this medication and has the ability to use the medication as prescribed. Any other medication prescribed is considered non-emergent and must be left in the nurse's office.

1. Medication _____ Dose _____ Time _____
2. Medication _____ Dose _____ Time _____
3. Medication _____ Dose _____ Time_____

No. of Days to be administered at School _____ Duration of School Year: YES NO

Special Instructions _____

_____

_____ _____

Date **Signature of Licensed Health Care Provider**

Printed Name _____

Address/Phone Number _____

I hereby give my permission for the above named student to take the above prescription(s) at school as ordered and in accordance with USD 253 Board Policy JGFGB. I understand that any school employee who administers any drug 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 drug reaction suffered by the student because of administering such a drug.

☐ Emergency Medication Only: My child may carry inhaler/emergency medication (asthma, severe allergic reaction, diabetes managements) with him/her. This student has been instructed in the proper use and storage of this medication and has the ability to use the medication as prescribed. Any other medication prescribed is considered non-emergent and must be left in the nurse's office.

I hereby authorize USD#253 staff and _____ and his/her staff to share health
NAME OF YOUR DOCTOR
and medical record information about my child. I understand this information will be strictly confidential and will not be released to any other party without prior written consent.

_____ _____

Date **Signature of Parent or Guardian**

Printed Name _____

Address/Telephone/email _____

Note: The medication must be furnished by the parent and brought to school in the original container, labeled correctly by the pharmacy or physician, stating the name of the medication dosage and number of days to be administered at school.

Return completed form to the School Nurse at your child's school.

Emporia
PUBLIC SCHOOLS

EMPORIA USD 253, Emporia, Kansas 66801

Request for Over-the-Counter Medication to be Administered at School

Name of Student _____ Date of Birth _____

School _____ Grade _____ Teacher _____

1. Medication _____ Dose _____ Time _____

Reason for the medication _____Duration of School Year: YES NO

Special Instructions _____

2. Medication _____ Dose _____ Time _____ Reason

for the medication _____Duration of School Year: YES NO

Special Instructions _____

I hereby give my permission for the above named student to take the above OTC medication(s) for the reasons specified by me above at school in accordance with USD 253 Board Policy JGFGB. Any changes in the type of medication, dosage and/or time of administration must be accompanied by a new parent/legal guardian request.

I understand that this form merely reflects the request that the above-named student be allowed to take medication at school under school supervision and that USD 253 bears no responsibility for ensuring the medication is administered except when the student requests the medication. When administered, the nurse or UAP shall complete documentation of medication administered.

I understand that it is my responsibility to furnish this medication in the original manufacturer container with all labels intact. Deviations from label directions will require a written provider/physician order. Medication should not be sent to school with a student riding school transportation; rather, Parent/Guardian is requested to bring their student's medication to the school and give it to the school secretary or nursing services staff. Upon receipt of a medication, nursing services will verify the medication, dosage, and reason.

I understand that by giving my permission for the administration of this medication, any authorized school employee who administers any drug to my student as prescribed by the parent/legal guardian shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such a drug. After medication is administered, students will be observed for possible reactions to the medication either at the site of administration or in the classroom as a part of the normal routine. I understand that the first time a child takes a medication should not be at school due to possible reaction.

I hereby authorize USD#253 staff and _____ and his/her staff to share health

[NAME OF YOUR DOCTOR]

and medical record information about my child. I understand this information will be strictly confidential and will not be released to any other party without prior written consent.

_____ _____

Date **Signature of Parent or Guardian**

Printed Name _____

Address/Telephone/email _____

Return completed form to the School Nurse at your child's school.