Sedgwick Public Schools - USD 439
Phone (316) 772-5604 / kmosiman@usd439.com

Permission for Medication at School

For students to receive medication while at school, the following form must be appropriately completed and returned to school prior to being administered.

Name of Student _____ DOB _____

School year _____ Grade _____ School _____

Medication _____

Dosage and route _____

Time _____ Condition being treated _____

Physician's name (please print) _____ Phone Number _____

Signature of Physician or Dentist _____ Date _____

I hereby give my permission for my child, _____, to take the above medication at school as ordered above.

I understand that it is my responsibility to furnish the medication and it must be in the original container appropriately labeled by the pharmacy, or physician, stating the name of medication, the dosage, and times it is to be administered.

I certify that my child has previously had at least one dose of the above medication and did not have an adverse reaction to it.

I further understand that any school employee who administers any prescription or nonprescription medication to my child, in accordance with the written instructions, shall not be liable for damages, injury, or death which might occur from an adverse drug reaction suffered by my child as a result of administering such drug.

I authorize USD 439 Health Services personnel to exchange information regarding this request with the above named physician and with the pharmacy as identified on the affixed pharmacy label.

Signature of Parent/Guardian _____ Date _____

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