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

Permission for SELF-Administration of Medication at School

Name of Student_____ DOB_____

School year _____Grade _____ School _____

Medication_____

Dosage and Route _____

Conditions under which the medication is to be given: _____

_____

Any additional circumstances under which the medication is to be given: _____

_____

Length of time medication is to be administered: _____

_____

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

I understand it is my responsibility to furnish the medication.

I acknowledge that the school incurs no liability for any damage, injury, or death resulting directly or indirectly from the self-administration of medication and agree to release, indemnify, and hold the district and its officers, employees and agents, harmless from and against any claims relating to the self-administration of such medication.

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

My child has been instructed on self-administration of the medication and is authorized to do so in school.

Signature of Parent/Guardian _____Date _____

Signature of Health Care Provider_____Date _____

Revised 5/13/2019