Sedgwick Public Schools - USD 439
Phone (316) 772-5604 / Fax (316) 215-7911
kmosiman@usd439.com

Permission for Self-Administration of Medication at School

Name of Student____ DOB ________________

School year _____________________________Grade _________________ School ____ *USD 439* ______

Medication____

Dosage and Route ____

Conditions under which the medication is to be given: ____

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

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Length of time medication is to be administered: ____

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

I understand it is my responsibility to furnish this 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 _________________