

Health Office\* Unified School District 248  
415 North Summit\* Girard, KS 66743  
phone: 620-724-4076 fax: 620-724-6136

## Request for Medication Administration

Name of student: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time of day to be given: \_\_\_\_\_

Reason for RX: \_\_\_\_\_

Possible Adverse Reactions: \_\_\_\_\_

Date prescribed: \_\_\_\_\_

Signature of Physician or Dentist: \_\_\_\_\_

(required for prescription medications)

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I hereby give my permission for \_\_\_\_\_  
to take the above named medication at school.

I understand that any school employee who administers said drug to my child in accordance with written instructions from the physician or dentist shall not be held liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug.

I further understand that with regards to over-the-counter medications, I have consulted a physician in its use and am following his or her advise. I will not hold any school employee liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug.

Date: \_\_\_\_\_ Signature of parent or guardian: \_\_\_\_\_

**Medication is to be brought to school in its original container.  
The first dose of medication may not be given at school.**