McPherson County Schools Health Services

REQUEST FOR MEDICATION TO BE ADMINISTERED AT SCHOOL

Student _________________________ DOB_________ School_______________ Grade/Teacher_________________

PHYSICIAN DIAGNOSIS / REASON FOR MEDICATION: ____

☐ **EMERGENCY MEDICATION ONLY:** Student may carry inhaler / emergency medication (asthma, severe allergic reaction, diabetes management) with them. This student has been instructed in the proper use and storage of this medication and has the ability to use the medication as prescribed.

Medication #1: ___________________________________ Dosage: _____________ Time:___________ Route: _______

Medication #2: ___________________________________ Dosage: _____________ Time:___________ Route: _______

Medication #3: ___________________________________ Dosage: _____________ Time:___________ Route: _______

Duration of medication:_____________________________Special instructions:__________________________________

____Allergies____

Licensed Health Care Provider Signature ____Date ________________
(M.D., D.O., D.D.S., A.R.N.P., or P.A.)
Printed Name of Licensed Health Care Provider ____

Address___________________________________Telephone_____________________Fax________________________

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PARENT / GUARDIAN PERMISSION TO ADMINISTER MEDICATION / INFORMATION EXCHANGE

I hereby give my permission for my child to take the above prescribed medication at school as ordered. I understand that it is my responsibility to furnish the medication in the original container appropriately labeled by the pharmacy / manufacturer or physician stating the name of the medication, the dosage, time to be given, and number of days to be administered at school. Any school employee who administers any medication in accordance with written instructions from the prescribing health care provider shall not be liable for damages as a result of any adverse drug reaction suffered by the student. If the student self-administers the medication, I acknowledge that the above named student has been instructed on self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication. I understand the school policy regarding medication.

I also give permission for the exchange of confidential health information between the school nurse, other representatives of my child's school, and the prescribing health care provider/pharmacy in the event a question or concern arises. I may revoke this consent to release information in writing and dated at any time except to the extent that action has been taken or information disclosed pursuant to signed consent. This consent shall remain in effect for a period of one year from signature date. To revoke this authorization, I should contact: my child's school or McPherson County Special Education Cooperative, 514 N Main, McPherson, KS 67460. Once information is disclosed, it may no longer be subject to HIPAA protections.

☐ **EMERGENCY MEDICATION ONLY:** My child may carry inhaler / emergency medication (asthma, severe allergic reaction, diabetes management) with him/her. He / She has been instructed in the proper use and storage of this medication and has the ability to use the medication as prescribed.

Parent/Guardian Signature____Date__________________

Printed Name of Parent/Guardian____

Address____Telephone_________________________

School Nurse Review of order and procedure with student if self-administered. Completed____________________________
4/16/15