Request for Medication Administration or Treatment to be performed during School Attendance
USD 500 Kansas City Kansas City, Ks Public Schools

Name of Student_____ **Grade**_____

School _____ **Teacher**_____

Medication/Treatment_____ **Treatment Plan Attached** _____

Dosage of Medication_____ **Date of Medication** _____

Treatment Started_____**Time to be given at School** _____

Duration of Medication/Treatment _____ **#days** _____

Diagnosis_____

Physician signature_____ **Physician telephone** _____

Please print Physician name _____

Addendum:
Pertinent medical and/or emergency information regarding my child may be shared with USD 500 faculty and staff who need to know for the health and safety of my child.
Parent/Guardian's signature_____

Parent Consent

I give permission for_____**to receive the above medication and /or treatment at school as ordered. I understand that it is my responsibility to furnish prescribed medication. I further understand that any school employee who administers any drug to my child in accordance with instructions from the physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered because of administration of such drug. I authorize USD 500 personnel and my child's health care provider to exchange verbal and/or written information regarding the health needs of my child at school.**

Signature of Parent Guardian_____ **Date**_____
Home Telephone # _____**Ce*ll* #** _____**Work #**_____
Emergency number # _____

Medication must be brought to school in the original container labeled by the pharmacy.