USD #417

Medication Request Form

17 South Wood Street

Council Grove, KS. 66846

CGES Phone: (620) 767-6851, Fax (620) 767-6942

PHES Phone (785) 499-6313, Fax (785) 499-5342

CGJH/HS Phone (620) 767-5149, Fax (620) 767-7280

Email: 417nurse@cgrove417.org

Request for Medication to be Administered During School Attendance

Name of Student: _____

Grade Level: _____ Teacher: _____

Medication : _____ Dosage: _____

Date Medication Started: _____ Reason for Rx: _____

Time of Day Medication is to be Given: _____

Anticipated Number of Days to be Administered at School: _____

Possible Side Effects: _____

Date: _____ _____

Signature of Physician

I hereby give my permission for _____ to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any drug to my student in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug.

Date: _____ _____

Signature of Parent

*NOTE: The medication is to be brought to school in the original container appropriately labeled by the pharmacy, or physician, stating the name of the medication, the dosage, and the number of days to be administered at school.