School Year

20____ - 20____


School Fax

316-554-_____

Permission to Administer Medication
Haysville Public Schools
Health Services Department

## Part A – Parent to Complete

Name of Student: _____ Date of Birth: _____ Grade/Teacher: _____

The medication listed below must be taken during school hours as directed by the health care provider. I grant permission for Haysville Schools to exchange information with my child's health care provider and dispensing pharmacy identified on the medication label as deemed necessary.
I hereby request that Haysville Schools cooperate with the prescribing health care provider and assist with the administration of medication pursuant to the policy of the Haysville Schools. I also certify that my child has received least one dose of the medication requested above and has not had any adverse reactions to it.
I have reviewed the above statements and agree to abide by Haysville Schools School District Policy regarding the administration of medication/procedures at school. I further release Haysville Schools and school personnel from liability when my child self-carries and self-administers medication.

_____ _____ _____
Parent/Legal Guardian Signature | Printed Name of Parent/Legal Guardian | Today's Date

_____ _____ _____
Home Phone | Cell Phone | Work Phone

_____ _____ _____
Parent Designee Name | Parent Designee Cell Phone | Parent Designee Work Phone

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## Part B – Health Care Provider to Complete

| Medication/Treatment | Dosage / Route | Time / Frequency | Diagnosis(es) / Indication |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Special Instructions: _____
_____

_____ _____ _____
Signature of Physician/APRN/PA | Printed Name of Physician/APRN/PA | Name of Supervising Physician **for APRN/PA**

_____ _____ _____
Health Care Provider Phone Number | Health Care Provider Fax Number | Today's Date

***This student has demonstrated the skill level necessary to self-administer and carry such medication/treatment.***

☐ **Yes** _____ _____
Signature of Physician/APRN/PA | Medication(s)/Treatment(s) that can be self-administered

***I agree to allow my student to self-administer and carry medications approved by the above provider.***

☐ **Yes** _____
Signature of Parent

# Permission to Administer Medication
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# Health Services Department

Board Policy:

PRESCRIBED MEDICATION OR OVER-THE-COUNTER MEDICATION WILL BE GIVEN AT SCHOOL ONLY UPON WRITTEN REQUEST FROM BOTH THE LAWFUL GUARDIAN AND THE PUPIL'S LOCAL ATTENDING PHYSICIAN. THESE WRITTEN REQUESTS ARE **REQUIRED BEFORE ADMINISTRATION** OF EITHER THE SHORT TERM OR MAINTENANCE MEDICATION IS INITIATED.

This written statement will be kept on file at the school for the duration of the stated treatment. Long-term treatment will be updated **annually**. A change in medication dosages requires a new written notification with the attending physician's signature.

**Medications:**

1. Prescribed medication will be provided to the school by the lawful guardian in a properly labeled crushproof container. The label shall give the following information:
    a. Pupil's name
    b. Name of medication
    c. Dosage and directions for administration
    d. Date
    e. Prescribing physician's name.

2. It is the lawful custodian's responsibility to assure the medication and dosage in the container is the same as is described by the label.