

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 review the statements on the back and agree to abide by Haysville Schools School District Policy regarding the administration of medication/procedures at school.

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

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 such medication/treatment.

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

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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.