Kearney Public School
Health Services

Parental Request for In-School Medication

Name _____ Date of Birth _____

School _____ Grade _____ Teacher_____

I give permission for _____to be given the following medication by the School Nurse or other unlicensed trained school personnel:

Name of Medication_____

Dosage of Medication_____

Date/s to be given_____

Time to be given/intervals in between doses_____

Route of Medication_____

Purpose of Medication_____

***Prescription medication*:** The medication must be in the original container with a current pharmacy label that includes: student name, medication, dose and time, date of prescription and the physician's name. Medication can only be given as instructed on the label.

***Over the Counter medication*:** The medication will be provided by the parent, be in the original container, and labeled with the student's name, dose and time. Medication can only be given as directed on the bottle for age and dose. Any changes in the manufacturer's recommendation will require a written order from the physician.

Any medication not properly labeled or stored can not be given at school. No medication can be given without completion of this form. Medication can be withheld based upon nursing assessment. Parents will be notified.

All medications must be stored at the school nurse office, unless all requirements for self-management of a condition have been met.

Self Management Requirements

- Written request/authorization of the student's parent/guardian
- Receipt of a signed no-liability statement by parent/guardian
- Written authorization of the student's physician
- Development of a Self-Management Plan for the student
- Documentation of successful demonstration of student's management skills by the School Nurse

I am not aware of any side effects, adverse reactions or any other problems my student is experiencing with this medication. I understand that I am primarily responsible for monitoring the effects of this medication. The School Nurse has my permission to contact Dr. _____ or his designee, regarding this medication.

_____ _____

Parent/Guardian signature Date

Parent phone number in case of questions:_____