

**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 # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
Emergency number # \_\_\_\_\_

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