Humboldt Schools

High School	1020 New York	Humboldt, Kansas 66748	620.473.2251
Middle School	1105 Bridge	Humboldt, Kansas 66748	620.473.3348
Elementary School	1100 Central	Humboldt, Kansas 66748	620.473.2461
Pre-School	910 New York	Humboldt, Kansas 66748	620.473.3997

REQUEST FOR MEDICATION ADMINISTERED DURING SCHOOL HOURS

Student Name:	DOB:	School:	Grade:
Physician:	Physician Phone:		
Medication:	Dosage:	Route:	Time:
Duration of Prescription:			
Allergies:			
Special Instructions:			

INHALER RELEASE ONLY

Will this consent include the use of an inhaler?	**YES_____**	**NO_____**

The above student has been instructed in the proper usage of his/her inhaler. We, the undersigned, request that he/she be permitted to carry the inhaler on his/her person or keep it in a locker, purse or backpack, as we consider him/her responsible. We absolve the school district of any responsibility in safeguarding the student's inhaler. ***YES_____NO_____***

PHYSICIAN SIGNATURE	**Date**

I hereby give my permission for **Students Name**: ___________________________________to take the above prescription medication at school as ordered. I understand that it is my responsibility to furnish this medication and 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. I hereby certify that my child has previously received at least one dose of the above prescription and did not have an adverse reaction from it. I authorize disclosure of information regarding this medication between U.S.D. 258 and the prescribing physician.

PARENT/GUARDIAN SIGNATURE	**DAYTIME PHONE**	**DATE**

Medication will be provided to the school by the lawful custodian in a properly labeled crush proof container. **Two containers, one for school use only, should be requested from the pharmacist** when medication needs to be administered during regular school attendance hours. The label shall be affixed to the container(s) and shall give the following information:

- Student's Name
- Prescription Number
- Name of Medication and Strength of Medication
- Dosage and Directions for Administration
- Date Prescription was filled
- Prescribing physician's/dentist's name
- Expiration date when applicable
- Medication storage direction
- Any information required by the Kansas Pharmacy Practice Act

It is the responsibility of the lawful custodian to provide and maintain an appropriate supply of medication at school. Appropriate amount of medication means: Routine medication: a month's supply (20-21 doses) Short-term medication: 5-10 school days supply
The medication shall be brought to school by a lawful custodian and given to a school employee who will contact the school nurse. No medication will be given at school without the approval of the school nurse. Any change in medication dosages or administration schedules will require a new medication request form to be completed by the lawful custodian and the prescribing physician. A newly labeled medication container will also be required.
It is the lawful custodian's responsibility to assure that the medication and dosage in the container is the same as is described by the affixed label.

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E-mail: stephanie.splechter@usd258.net	Assistant Principal: Stephanie Splechter HMS	Fax: 620.473.3141
E-mail: danielle.smith@usd258.net	Pre-K Principal: Danielle Smith	

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