



St. Mary's School
 605 Monroe Street
 Ellis, KS 67637
 (785) 726-3185



Request for Medication to be Administered

(during school hours)

Student's Name: _____

Teacher: _____ Grade: _____

Medication: _____ Dosage: _____

Date Medication Started: _____ Reason for RX: _____

Time to be given at school: _____ For how long: _____

Who will be administering: _____

I hereby give my permission for _____
 to take the above prescription at school as prescribed. I understand that it is my responsibility to furnish the medication according to the guidelines of St. Mary's School. The medication is to be brought to school in original container, appropriately labeled by the pharmacy or physician stating the name of the medication, the dosage, and number of days to be administered. I further understand 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 because of administering such drug.

Date: _____ Signed: _____

Date	Time	Dosage	Admin. By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
