



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: \_\_\_\_\_

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

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