

**Permission to Administer Medication  
Haysville Public Schools  
Health Services Department**

**Board Policy:**

PRESCRIBED MEDICATION OR OVER-THE-COUNTER MEDICATION WILL BE GIVEN AT SCHOOL ONLY UPON WRITTEN REQUEST FROM BOTH THE LAWFUL GUARDIAN AND THE PUPIL'S LOCAL ATTENDING PHYSICIAN. THESE WRITTEN REQUESTS ARE **REQUIRED BEFORE ADMINISTRATION** OF EITHER THE SHORT TERM OR MAINTENANCE MEDICATION IS INITIATED.

This written statement will be kept on file at the school for the duration of the stated treatment. Long-term treatment will be updated **annually**. A change in medication dosages requires a new written notification with the attending physician's signature.

**Medications:**

- A. Prescribed medication will be provided to the school by the lawful guardian in a properly labeled crushproof container. The label shall give the following information:
  - a. Pupil's name
  - b. Name of medication
  - c. Dosage and directions for administration
  - d. Date
  - e. Prescribing physician's name
  
- B. It is the lawful custodian's responsibility to assure the medication and dosage in the container is the same as is described by the label.

_____		_____	
Name of Student to Receive Medication		Date of Birth	
_____		_____	
Print Name of Physician		Phone	
Name of Medication and Dosage to be given_____			
For the Diagnosis of_____			
Directions for administration and any other pertinent information:			
_____			
_____			
Requested starting date of treatment_____		Expected duration of treatment_____	
Request to administer the medication during regular school hours.			
_____		_____	
Signature of Parent/Guardian		Physician's Signature	
_____		_____	
Phone	Date	Phone	Date
_____		_____	
Address		Address	