Haysville USD 261
1745 West Grand
Haysville, KS 67060
(316) 554-2200
Fax (316) 554-2230

Date

Name:
Address:
City, State, and Zip:

This letter is intended to clarify your appeal of an official Board of Education policy as per allowing a student to keep on their person prescription medication. The Board has made an exception to their policy in the case of _____ and your parental request to allow him/her to carry a prescription. (insert student's name)

For this exception to go into affect, it will be necessary for you to comply with the following within thirty (30) days of receipt of this letter. To:

1) A Request by Student to Possess and Self-Administer Prescription Medication Form must be signed and on file in the District School Nurse's Office.
   You and your physician must sign form. Form is enclosed in this letter for you convenience.

2) The medication must be in a protective manner that it cannot be accidentally left or forgotten. Should the medication ever be located or found outside the Student's possession, the wavier to the Board Policy may be cancelled.

3) The parent agrees that the school may contact the physician prescribing the medication at the discretion of the school district.

Please note that the signing by the parent of the Medication form indicates agreement and acceptance to all items above.

Please be advised that the Board of Education certainly does not desire to make this a difficult situation for your family. The above steps are absolutely necessary, however, to afford the school district some protection from liable and potentially devastating financial loss due to possible litigation.

Thank you for your understanding,

Respectfully yours,

Dr. John Burke
Superintendent of Schools

Request by Student to Possess
And Self-Administer Prescription Medication

Dear Physician:

The below student and their legal guardian(s) have requested permission to carry on their person and self-administer a prescription drug prescribed by your office. This is in violation USD 261 district policy. To receive a waiver to said policy, it is necessary for this form to be signed by the prescribing physician. The district apologizes for any inconvenience this may cause you and we thank you for your time.

Name of Student_____ Date of Birth_____

Address_____

School_____Grade_____Teacher_____

Medication_____Dosage_____

Date Medication Started_____

Anticipated Number of Days to be administered at School_____

**It is absolutely necessary for the health and well being of this student that the above medication be carried on their person at all time during the school day. Further, absence of this medication when needed for even an extremely short period of time may cause very serious physical damage and/or harm to the student. As this student's physician, I herby request that the above student be allowed to carry and self-administer the drug(s) listed.

_____ _____
Signature of Physician Date

I herby give my permission for _____to take the aforementioned prescription at school. I understand that is my responsibility to furnish this medication. I further both request and give my permission that this student be allowed to carry said medication on their person and to self-administer such.
I hereby release Unified School District 261, the Board of Education, and all it agents, servants, and employees from any liability arising out of the above student's self-administration of the listed prescriptions and/or drugs.

_____ _____
Parent and/or Legal Guardian Date

_____
Witness