KENESAW PUBLIC SCHOOLS

PARENTAL REQUEST ALLOWING IN-SCHOOL MEDICATION

NAME: ____

DATE: ____

I request the school nurse, secretary, or teacher see that my child receives, as needed the following medication I have supplied.

1. Prescription Medication: I understand that prescription medication must be in the original container with the child's name, type of medication, dosage and times to be given. I also understand that any medication not properly labeled or loose pills will not be given at school.
   All medication must be taken to the office to be kept there during the school day.
   School personnel will administer no medication without the completion of this form or contact with the parent or guardian.

2. Over-the-Counter Medication: I understand I must provide school personnel with medication in a container labeled with my child's name, type of medication, dosage, and times to be given.

TYPE OF MEDICATION	DOSAGE	TIME(S) OF DAY
____________________________	_______________________	________________
____________________________	_______________________	________________
____________________________	_______________________	________________

Name of family doctor: ____

Parent signature: ____

Date: ___________________________________

Allergies: ____