Health Office*Unified School District 248
415 North Summit*Girard, KS 66743
(620)-724-4076

Emergency Medication Self-Carry Release

Name of student: _____
Grade: _____ Teacher: _____

Medication: _____
Dosage: _____ Time of day to be given: _____
Reason for RX: _____
Possible Adverse Reactions: _____
Date prescribed: _____

Signature of Physician or Dentist: _____
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I hereby give my permission for _____
to carry and self-administer the above named medication at school.

I understand that any school employee who administers said drug to my child in accordance with written instructions from the physician or dentist shall not be held liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug.

I further understand that with regards to above named medication, I have consulted a physician in its use and am following his or her advice. I will not hold any school employee liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug.

Date: _____ Signature of parent or guardian: _____

Medication is to be brought to school in its original container.
The first dose of medication may not be given at school.

____ Student demonstrated proper use of medication.