KENESAW PUBLIC SCHOOLS
PARENTAL REQUEST FOR IN-SCHOOL MEDICATION

NAME: _____ DATE: _____

I hereby request Kenesaw Public Schools, or its authorized representative, to administer the medication I have supplied and named below to my child, in accordance with the prescribing physician and/or parent's instructions, and agree to:

1. Provide directions to the school personnel providing the medication
2. Provide monitoring of the medication's effects, and assume full responsibility therefor.
3. Submit a **REVISED STATEMENT** signed by the physician prescribing the medication to the school secretary or nurse **if any of the information provided by the physician changes.**

Prescription Medication: I understand that the prescription medication must be in the original container labeled with the prescribing physician's instructions including the child's name, type of medication, dosage and times to be given, and expiration date after which no administration should 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 not administer medication without the completion of this form or contact with the parent.

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

NAME OF MEDICATION	DOSAGE	TIME(S) TO BE GIVEN
_____	_____	_____
_____	_____	_____

Family Doctor _____ Allergies _____

I understand that unlicensed school personnel may be assigned to provide medication to my child and hereby release the School District, Board of Education, and all employees, agents, and representatives of the School District from any liability concerning the providing or non-providing of the medication to my child.

Parent Signature _____ Date _____