LEE'S SUMMIT R-7 SCHOOL DISTRICT
ADMINISTRATION OF MEDICATIONS TO STUDENTS
(Parent Permission Form)

Name:_______________________________________ **Age:**_____ **Date of Birth:**_________

School: _______________**Grade**: _________ **Homeroom/Teacher:** _________________

****Drug Allergies**** (list) ____

Name of Medication to be given at school: _______________________________________

Physician Name: _________________________________ **Phone:** ____________________

Reason for Medication: ____

Time: ________________ **Dosage**: ___________________

_____ Daily (medication will be given daily until gone-parent will provide refill to the health room)
_____ As needed per student/parent request

☐ **I <u>DO NOT WANT</u> the mid-day dose of medication administered on early release days.**
I have given the first dose of this medication per Lee's Summit R-7 School District Policy.
_____ Yes ______ No

I give permission for __________________________ (student's name) to receive the above medication at school.

I give district employees permission to contact the student's physician directly to provide information on the student's condition or to obtain clarification of orders. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school district immediately if any information provided on this form changes or if administration of medication should cease.

NOTICE

Schools in this district are equipped with pre-filled epinephrine auto-syringes that can be administered in the event of severe allergic reactions that cause anaphylaxis. Epinephrine will be administered in accordance with written protocols provided by the authorized prescriber, except for students authorized to carry and self-administer epinephrine in accordance with Board policy.

Signature: _________________________**Relationship**: __________ **Date:** _________

Home Phone: ___________ **Work Phone**: ____________**Mobile Phone**: ___________

LSR7 Health Home LSR7 Home