UNIFIED SCHOOL DISTRICT NO. 325 PHILLIPSBURG

240 South Seventh Street
Phillipsburg, Kansas 67661
Ph: (785) 543-5281 Fax: (785) 543-2271
Email: "username"@usd325.com Website: www.usd325.com

Dear Parent/Guardian:

This letter is intended to inform you of the district policy on medications at school.

1. The State of Kansas has defined the administration of all prescription medicine as a nursing task that must fall under certain guidelines. If your child needs prescription medication administered at school:

    a. You will need to notify the school office.

    b. You will need to ask the doctor to prescribe two containers of medicine (one for home, and one original for school).

    c. Written instructions from the physician should accompany the prescription.

    d. You will need to complete the attached form and return it to the school building office.

2. We will continue to use the current form for allowing your child to take a non-prescription medication (Tylenol, cough drops, etc.) at school. You will be given an opportunity to sign this form during enrollment. If not, that form is available in your school building office. If you wish to allow the school to give non-prescription medicine when needed, you need to sign it and leave it with the school secretary.

Please call your principal if you have any questions or concerns. Thank you for your efforts to help us comply with these regulations.

Respectfully,
Michael E. Gower
Superintendent

AUTHORIZATION FOR MEDICATION / PROCEDURE TO BE ADMINISTERED AT SCHOOL & FIELD TRIPS (effective *2024-2025* School Year Only)

Part A

Parent/Legal Guardian to Complete

Name of Student: _____Date of Birth: _____ Grade/Teacher: _____

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school as indicated by my child's physician accordingly below. I understand that I must provide any prescribed medication in its original labeled container. I further understand that any employee who administers this medication(s) shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administrating such drug.

I also acknowledge the need and give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question, including communication concerning: 1. the prescription or treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube); 2. implementation of the treatment in school (e.g., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule); 3. student outcomes from the treatment (e.g., questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom); 4. and other pertinent issues related to the student's diagnosis, condition, or treatment.

_____ _____ _____

Parent/Legal Guardian Signature | Parent/Legal Guardian (Printed Name) | Today's Date

---

Part B

Physician to Complete

Current Diagnosis(es): _____ _____ _____

PHYSICIAN MEDICATION AND/OR TREATMENT ORDERS: (please specify)

Medication / Treatment	Dosage	Time / Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special Instructions: _____

_____

_____ _____ _____

Physician Signature | Physician Printed Name | Today's Date

Physician Phone Number _____