TOPEKA PUBLIC SCHOOLS
NURSING SERVICES
REQUEST AND PERMISSION
TO SUPERVISE THE TAKING OF MEDICATION AT SCHOOL

I request and authorize _____ to take at school under
school supervision (Name of Student)
_____ _____ for _____
(medication and individual dosage) (Time of Day) (Number of Days)
Teacher: _____ Grade _____
Diagnosed Illness (Optional): _____
Prescription No.: _____ Name of Pharmacy: _____

_____
(Parent, Lawful Custodian or Person Acting as Parent)

I hereby request and give permission for _____
(Name of Student)
to take the medication as indicated above. I understand this form merely reflects the request that the above-named student be allowed to take medication at school and that Topeka Unified School District No. 501 acknowledges this request and agrees to comply with the request if possible. I understand that Topeka Unified School District No. 501 does not, in any way, guarantee that the medication will be taken under supervision by the above-named student. I hereby release Topeka Unified School District No. 501, its officers and its employees, from any and all liability resulting from its failure to supervise the taking of the medication indicated above. I further hereby release Topeka Unified School District No. 501, its officers and its employees, from any and all responsibility for adverse effects of this medication and agree to indemnify them against any and all liability, loss, or damage they may incur or suffer as a result of the student named above taking or not taking the above medication.

_____ _____
(Date) (Parent, Lawful Custodian or Person Acting as Parent)

Date of Approval _____ Approved by _____
(Principal or Principal's Designee)

DATE	TIME	DOSAGE	SUPERVISED BY	COMMENTS/OBSERVATIONS

Stockroom No. 8709-00
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