JHCD-R

PARKWAY SCHOOL DISTRICT
AUTHORIZATION TO ADMINISTER SHORT-TERM OVER THE COUNTER MEDICATION

Name of Student _____ **Date of Birth**_____ **Age**____

School Year_____ Name of School _____Grade_____

Parent/Legal Guardian Name_____

Phone number(s) _____
(Cell) (Work) (Home)

Note to Parents/Guardians: Please review Parkway's medication policy and regulations at http://www.boarddocs.com/mo/pkysd/Board.nsf/Public# **Per school district policy, homeopathic and naturopathic medications, vitamins and supplements will not be administered at school or camp.**

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

I request that the above named student be allowed to take the following over-the-counter medication at school /camp/ field trip for up to 5 consecutive days:

Name of medication (no abbreviations): _____

Dosage: _____

Frequency/ Time(s): _____

Reason for medication/diagnosis: _____

Start Date _____ End Date_____ (up to 5 consecutive days)

Possible side effects: _____

Other medication currently being taken: _____

I am the parent or legal guardian of the above named student. I request that the school nurse, or in the nurse's absence the principal or principal's designee, be caretaker of and administer the above listed medication to my student. I have given the first dose of this medication at home. I release Parkway School District from the responsibility of any adverse side effects of this medication.

All over the counter medication must be in its original labeled container. Over the counter medication will only be administered per the dosage guidance on the bottle.

Other instructions: _____

Parent/Guardian signature: _____ Date: _____