JHCD-R

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

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

School Year_____ Name of School _____

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.

Other instructions: _____

Parent/Guardian signature: _____ Date: _____