PARKWAY SCHOOL DISTRICT
AUTHORIZATION TO ADMINISTER MEDICATION

JHCD.BP

School Year: _____ School Name: _____

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

Student Name: _____ Birthdate: _____ Grade: _____
Name of medication (no abbreviations): _____
Parent/Legal Guardian Name: _____
Phone number(s) : _____
(Cell) (Work) (Home)

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 the caretaker of and administer the above-listed medication to my son/daughter. I have given the first dose of this medication at home. I release Parkway School District from the responsibility for any adverse side effects of this medication.

All medication (prescription or over-the-counter) must be in its original labeled container and not expired.
Other instructions: _____

Parent/Guardian signature: _____ Date: _____

Note to Parents/Guardians and Licensed Prescribers: Please review Parkway Board Policy JHCD.BP

TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

I request that the above-named student be allowed to take the following medication at school:

Name of medication (no abbreviations): _____

Dosage: _____ Frequency/ Time(s): _____

Reason for medication/diagnosis: _____ Duration for medication: _____

Possible side effects: _____

Other medication currently being taken:_____

Physician/Licensed Prescriber's Name:_____
(printed)
Phone Number: _____ Fax Number: _____

Physician's Signature: _____Date: _____

Revised 05.17.24