Parker School District 60-4

Prescription Medication Permission Form 2026-2027

Phone: (605) 297-3456 Fax: (605) 297-4381

For **prescription medications**, both Parent and Physician must complete and sign the form before medication(s) can be given. For **over-the-counter medication(s)**, a Parent/Guardian must complete the form and sign before medication(s) may be given at school. Parker School District encourages medication administration to be arranged outside of school hours, if possible.

**********To Be Completed by Healthcare Provider and/or Parent/Guardian **********

Student's Name:_____ Birth Date:_____

Parent(s)/Guardian:_____ Phone#:_____

Allergies:_____

Medication(s):_____

Dosage: _____

Route of administration:_____

Time(s) to be administered:_____

Duration (beginning & discontinue date OR "school year"): _____

Possible side effects:_____

Diagnosis:_____

If this is an emergency medication (i.e. inhaler, EpiPen®, Auvi-Q®, etc.), has the student been instructed to self-administer and may he/she do so? Yes _____ No _____

Physician's Name (prescription only): _____ Phone #: _____

_____ _____

Physician Signature Date

**********To be completed by Parent/Guardian**********

Option I: _____ (initial) I request and authorize personnel at the above-named school to supervise medication/treatment prescribed on this form to my child. I understand that the medication must be delivered by a parent, guardian or responsible adult in its original pharmacy or manufacturer's container and include the name, dosage and prescribing clinician's information. I acknowledge that I will not hold the Parker School and/or District employees responsible for damages or injuries resulting from medication administration. I understand I am responsible for picking up any unused or expired medication on or before the last day of school or one week after the last dose is given. If the medication is not picked up, it will be destroyed.

Option II: _____ (initial) I request and authorize my child to keep and self-administer his/her own medication at school. I relieve the school district and personnel of all responsibility associated with this self-administration. Medications which can be self-administered include physician-ordered inhalers and EpiPens®, Auvi-Q®, and over-the-counter medications (e.g. ibuprofen, acetaminophen, cough drops, Tums). Only medication for one day at a time may be brought to school. This option is only available to 7-12 grade students. For your child's safety and the safety of other children, JK-6 students are not allowed to carry/self-administer any medication at school, with the exception of EpiPens®, Auvi-Q®, rescue inhalers, and/or cough drops.

_____ I wish to be notified whenever the above-mentioned medication is given.

_____ I DO NOT wish to be notified whenever the above-mentioned medication is given.

Parent/Guardian Signature: _____ Date: _____