

Irene-Wakonda School District #13-3

Secondary School

PO Box 5
Irene SD 57037
605-263-3313

Larry Baker, Supt/HS Principal
Deb Lyle, Elementary Principal
Pam Rudd, Business Manager

Elementary School

PO Box 268
Wakonda SD 57073
605-267-2644

Medication Permission Form

Student Name Birthdate Grade School Year

Over-the-Counter Medication: By initializing below, I give permission for school personnel to administer the following medication(s) as needed to my student for minor discomfort or injury. Medications supplied by the school may vary between buildings and grade levels.

_____ Acetaminophen (Tylenol or store brand)
_____ Ibuprofen (Advil, Motrin or store brand)
_____ Cough drop (non-medicated)
_____ Topical medication (antibiotic ointment, pain relieving cleansing spray, hydrocortisone cream, anti-itch spray)
_____ Antacid (Tums)

Parents may also supply other over-the-counter medications. Please list below:

Medication name: _____ Dosage: _____

Reason given: _____ Time: _____

Short term Prescription Medication

Medication name: _____ Dosage: _____

Reason given: _____ Time: _____

On early dismissal or late start days, please indicate one of the following:

_____ Do NOT administer medication on early dismissal days _____ Administer medication at prescribed time

_____ Do NOT administer medication on late start days

School personnel who administer medication according to proper dosing instructions shall be held harmless for any adverse reaction experienced by the student. My student has previously taken the medication(s) listed above with no known adverse reaction.

Parent/Guardian printed name:

Parent/Guardian signature:

Date: