Irene-Wakonda School District #13-3

Secondary School

PO Box 5
Irene SD 57037
605-263-3313

David Hutchison, Superintendent
Joel McNeely, Secondary 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:**