Medication Request/Release
2020-2021

Student: ____

Grade: ____

I request and authorize administration or their designee at the Parker Public School to supervise the below stated medication and dosage at the stated time as prescribed by:

Doctor: ____

Doctor's phone number: ____

Medication: ____

Dosage: ____

Specific time? ____

Method (oral, drops, etc.) ____

Precautions and reactions to observe and report:

____

____

____

I understand that the medication shall be provided in a bottle showing the name, physician's name and dosage of the drug to be taken.

I understand that the school district and individuals involved will not be liable for any adverse effects of the medication.

IF THIS MEDICATION IS NOT GIVEN DAILY:

_____I wish to be notified whenever this medication is given.

_____I do not wish to be notified whenever this medication is given.

Signed (Parent or guardian):____

Date: ____