HEALTH SERVICES
Boulder Valley School District

Medication Administration Authorization

The undersigned parent(s) or guardian(s) of _____ hereby request personnel employed by the Boulder Valley School District to see that said child receives _____ (medication) at _____ (time) as described by prescribing health care provider.

It is required by the Boulder Valley School District as a condition to its agreement to administer any medication, that the medicine has been prescribed by a health care provider and that it has been furnished by the parent(s) or guardian(s) of the student with an appropriate label stating the child's name, name of the medicine, times at which medication is to be administered, the dosage and the date when the medication is to be stopped. It is understood that the medication will be administered solely at the request of and as an accommodation to the undersigned parent(s) or guardian(s). In consideration of the acceptance of the request to perform this service by any personnel employed by the Boulder Valley School District, the undersigned parent(s) or guardian(s) hereby agree(s) to release the said institution and their personnel from any legal claim(s) which they now have or may hereafter have arising out of the administration of (or failure to administer) the medication to the student.

Dated this _____ day of _____, 20_____.

_____ _____
Name of Health Care Provider prescribing medication School Child Attends

_____
Signature of Parent/Guardian

HEALTH CARE PROVIDER'S SIGNED ORDER FOR MEDICATION AT SCHOOL

Student's Name: _____ Medication: _____

Route of Administration: _____ Dosage (total mg/dose): _____

to be given at: _____ from _____ to _____
time date date

Purpose of Medication: _____

Possible Side Effects: _____

_____ _____
Health Care Provider's Signature Date

For inhalers & EpiPens only: Provider, please sign below to give permission for student to carry and self-administer the inhaler and/or epinephrine ordered on this form.

_____
Health Care Provider's Signature and Date