File: JLCD-E

Highland Weld Re-9 School District

Permission for Over the Counter and Prescription Medication
BOTH Must Have Physician's Authorization

NAME OF STUDENT_____ DOB _____ GRADE _____

MEDICATION_____

DOSAGE_____ ROUTE_____

PURPOSE OF MEDICATION_____

TIME OF DAY MEDICATION TO BE GIVEN_____

POSSIBLE SIDE EFFECTS_____

START DATE_____END DATE_____

DATE_____PHYSICIAN SIGNATURE_____

PRINTED PROVIDER NAME_____

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It is understood that the medication above is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by the Weld Re-9 School District, the undersigned parent or guardian hereby agrees to release the Weld Re-9 School and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of medication.

I HEREBY GIVE MY PERMISSION FOR_____ TO TAKE THE ABOVE MEDICATION AT SCHOOL AS ORDERED. I HAVE READ AND UNDERSTAND THE WELD RE-9 SCHOOL DISTRICT MEDICATION PROCEDURE AND WILL ABIDE BY THOSE PROCEDURES. I UNDERSTAND IT IS MY RESPONISIBLITY TO PROVIDE THIS MEDICATION TO THE SCHOOL.

DATE_____PARENT/GUARDIAN SIGNATURE_____

NOTE: Prescription medication is to be brought to school in the original properly labeled container stating the student's name, name of the drug, dosage, time for administering, and name of the medical provider printed by the pharmacy. Over the counter medications are to be brought in the original container labeled with the student's name. We must receive this signed authorization form to give medication. A new Permission for Medication form must be completed for each medication change and each school year.