

Permission for Medication

Name of Student _____

School _____ Grade _____

Medication _____ Dosage _____

Purpose of the medication

Possible side effects

Anticipated number of days to be given at school _____

Date

Signature of health care practitioner
(or health care practitioner prescription)

It is understood that the medication 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 Garfield County School District No. 16, the undersigned parent or guardian hereby agrees to release the Garfield County School District No. 16 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 the medication.

I hereby give my permission for _____ to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication.

A new Permission for Medication form must be completed for each medication change and each school year.

Parent/guardian printed name

Date

Signature of parent or guardian

Revised: December 14, 2010

Revised: December 13, 2022