Permission for Medication Administration at School

The parent/guardian of _____ ask that school/child care staff give the following medication
Student's Name
_____ at _____ to my child, according to the Health Care
Name of Medication *Dosage Time(s)*

Provider's signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, route, date medicine is to be stopped, and licensed Health Care Provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with the child's name. Dosage must match the signed Health Care Provider authorization, and medicine must be packaged in the original container.

The school agrees to administer medication prescribed by a licensed Health Care Provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff. All medication(s) left at the school will be discarded according to the most current state regulatory recommendations for safe medication disposal.

***By signing this document, I give permission for my child's Health Care Provider to share information about the administration of this medication with the school staff delegated to administer medication*.** 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 Woodland Park Re-2 School District, the undersigned parent or guardian hereby agrees to release the Woodland Park Re-2 School District 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.

Parent/Legal Guardian's Name_____

Parent/Legal Guardian Signature _____ Date _____

Contact Phone Numbers (home, work, cell, etc.) _____

Health Care Provider Authorization

Student's Name:		Birthdate:
Medication:	Dosage:	Route:
To be given at the following times:	Start Date:	End Date:
Special Instructions:		
Purpose of Medication:		
Side Effects to be reported:		

_____ _____
Signature of Health Care Provider with Prescriptive Authority Date

_____ _____/_____
Name of Health Care Provider Phone & Fax Number

_____ _____
Signature of Child Care Health Consultant or School Nurse Date