

Permission for Medication

Name of student _____

School _____ Grade _____

Teacher _____

Medication _____ Dosage _____

Purpose of medication _____

Time of day medication is to be given _____

Possible side effects _____

Anticipated number of days it needs to be given at school _____

Date _____

Signature of physician

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 Swink School District, the undersigned parent or guardian hereby agrees to release the Swink 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.

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.

Date _____

Signature of parent or guardian

NOTE: The prescription medication is to be brought to school in a container appropriately labeled by the pharmacy or physician stating the name of the medication and the dosage.

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Swink School District #33, Swink, Colorado