Permission for Medications at School

Name of Student:____

Medication:_________________________________ Dosage:____________

Time to be given:__________________________ Route:__________________

Indications for PRN medications (be specific):______________________________

Anticipated number of days medication needs to be dispensed at school:_____________

Physician Signature:_________________________________ Date:____________

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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 employed by the district, the undersigned parent or guardian hereby agrees to release Salida School District R32J 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 medication at school as ordered. I understand that it is my responsibility to furnish this medication in original container from pharmacy. Please ask the pharmacist to separate medicine bottle to keep one at home and one at school.

I understand that by signing this form, I am also granting permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

As a courtesy to the parent/guardian, this form will be faxed to the following prescribing practitioner: _________________________________ fax:___________

_________________________________ _________________________________
Parent/Guardian Name Parent/Guardian Signature

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Date

Contact the school nurses with questions:

Missy Tanner RN, Longfellow	530-5264	Fax: 539-5072
Cari Beasley RN, SMS	530-5316	Fax: 530-5364
Rebecca Capozza RN, SHS	530-5408	Fax: 539-2407
Lindsay Haarmeyer RN, SECC	530-5358	Fax: 539-1844