

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: _____



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

Date

Contact the school nurses with questions:

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