St. Vrain Valley School District - Department of Student Services

Permission for Medication

School Year:
20__ - 20__

Dear Parent

We attempt to discourage administration of medication in the schools. However, if your physician decides it is necessary for your child to receive medication during the school day, his/her approval and specific directions must be provided to the school. It is recommended the first doses of medication be administered at home.

Send the medication to the school in the original or a duplicate box or bottle with the current prescription label on the container. Upon request, pharmacists have labeled empty containers to be used.

Please have your physician record his/her instructions regarding the administration of your child's medications.

Name of student_____
School_____ Grade_____ Teacher_____

TO BE COMPLETED BY PHYSICIAN

Medication_____ Dosage_____
Purpose of Medication_____
Time of day medication is to be given_____ Possible side effects _____
_____
Days to be given at School (Not to exceed the current school year)_____

_____ _____ _____

Date **Printed Name of Physician** **Signature of Physician**

TO BE COMPLETED BY PARENT

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 any person employed by the St. Vrain Valley School District, the undersigned parent or guardian hereby agrees to release the St. Vrain Valley School District and its personnel from any legal claim which they now have or may hereafter have arising out of the administration of or failure to administer the medication to the student.

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**_____Phone#_____

Date_____ **Health Clerk** _____Date _____**School Nurse**_____

Se entiende que el medicamento es administrado solamente al ser solicitado o como un arreglo hecho por el abajo firmante padre o guardian. En consideracón al la aceptación de lo solicitado para que este servicio pueda ser desempeñado por cualquier persona empleada por el Distrito Escolar del Valle de St. Vrain, el abajo firmante padre o guardian comunica y está de acuerdo por medio de la presente que libera al Distrito Escolar del Valle de St. Vrain y su personal de cualquier demanda legal que puedan tener ahora o pueda surgir o crearse en el futuro por la administración del medicamento al estudiante.

Por medio de la presete Yo doy mi autorización o permiso para que
_____tome la receta o medicamento en la escuela como fue ordenada.
Entiendo que es mi responsabilidad el proveer o surtir ésta medicina.

Fecha _____Firma del
Padre/Madre/Guardian_____

Fecha Director (a) Fecha Empleada de Salud