MONTE VISTA SCHOOL DISTRICT C-8

PERMISSION FOR MEDICATION

Student's Name: _____ Date of Birth: _____

School: _____ Teacher: _____ Grade: _____

Medication: _____ Dosage/Route: _____

Number of days to be given at school: _____ or school year _____ Time: _____

Purpose of Medication: _____

Possible Side effects: _____

Date: _____

Phone number: _____ _____

Health Care Provider Signature

_____

Please Print Name

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 Monte Vista School District, the undersigned parent or guardian hereby agrees to release the Monte Vista 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 the medication.

Date: _____ _____

Signature of Parent or Guardian

NOTE: All medications, prescription or over the counter (OTC), are to be brought to school in its original container appropriately labeled by the pharmacy or physician stating the name of the medication and dosage. Please do not send medications to school with students. Please do not send medications in Ziploc baggies, etc. The top portion of this form MUST be completed by a healthcare provider. The lower portion MUST be completed by parent or guardian before any medications may be given at school.