

## Permission for Medication

Name of student \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

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 health care practitioner*

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 Big Sandy 100J School District, the undersigned parent or guardian hereby agrees to release the Big Sandy 100J 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 \_\_\_\_\_ (*name of student*) to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication.

A new Permission for Medication form must be completed for each medication change and each school year.

\_\_\_\_\_  
*Parent/guardian printed name*

\_\_\_\_\_  
*Parent/guardian signature Date*

Date \_\_\_\_\_

*Signature of parent or guardian*

Issued: May 18, 2011  
Revised: June 30, 2021  
Adopted: August 4, 2021

Big Sandy School District 100-J, Simla Colorado