

MAPLETON PUBLIC SCHOOLS
Adams County School District No. 1
Department of Student Services

File: JLCD-E

PARENT'S REQUEST FOR GIVING MEDICATION AT SCHOOL

I request that my child _____ receive the medication prescribed
(Child's Name)
by _____ at _____ for
(Physician's Name) (Telephone Number)
the period from _____ to _____
(Starting Date) (Ending Date)

according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child's name, name of medicine, when medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. In consideration of the acceptance of the request to perform this service by any authorized person employed by the Mapleton Public School District, the undersigned parent/guardian hereby agrees to release the Mapleton Public 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 the above named student to take the prescription listed below at school or school sponsored activities as ordered. I understand that it is my responsibility to furnish this medication.

(Signature of Parent/Guardian)

(Date)

HEALTH CARE PROVIDER AUTHORIZATION

Child's Name: _____ Birth date: _____

Name of Medication: _____

Dosage: _____ Route: _____

To be given at school at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported to the parent: _____

(Signature of Health Care Provider With Prescriptive Authority)

(Date)

SCHOOL APPROVAL

School: _____

(Principal's or Designee's Signature)

(Date)

Copy faxed to School Nurse Consultant at 303-853-1145 _____
Initial

Please ask the pharmacist for a separate medication bottle to keep at school