Boulder Valley School District
Excellence and Equity

Return <u>only</u> if your student takes prescription or over-the-counter medication or carries an inhaler …
this form MUST be <u>signed by the doctor for EACH medication they will be taking overnight</u>

<u>MEDICATION ADMINISTRATION AUTHORIZATION</u>

The undersigned parent(s) or guardian(s) of ____
hereby request personnel employed by the Boulder Valley School District RE-2 to see that said child receives

_____________________________________ at ______________________ as described by prescribing physician.
(name of medication) (time)

It is required by the Boulder Valley School District as a condition to its agreement to administer any medication, that the medicine has been prescribed by a physician or dentist and that it has been furnished by the parent(s) or guardian(s) of the student with an appropriate label stating the child's names, name of the medicine, times at which medication is to be administered, the dosage and the date when the medication is to be stopped. It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent(s) or guardian(s). In consideration of the acceptance of the request to perform this service by any personnel employed by the Boulder Valley School District RE-2, the undersigned parent(s) or guardian(s) hereby agree(s) to release the said institution and their personnel from any legal claim(s) which they now have or may hereafter have arising out of the administration of (or failure to administer) the medication to the student.

Dated this _____ day of ______ 2015.

____ ____
Name of Physician or Dentist prescribing medication Signature of Parent or Guardian

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<u>PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL</u>

Student's Name ____ Medication ___________________________

Route of administration ______________________________ Dosage (total mg/dose)__________________________

to be given at _____________________ from ______________________ to __________________________.
(time) (date) (date)

Purpose of medication ____

Possible side effects ____

____ _________________________
Physician's Signature Date

<u>For inhalers & EpiPens only</u>: Doctor, please sign below to give permission for student to carry and self-administer the inhaler and/or EpiPen ordered on this form.

____
Physician's Signature & Date