



NURSING SERVICES
1002 Hastings St.
Delta, Co. 81416
970-874-7607 Fax 970-874-9505

Permission for Medication

If your child must have medication of any type, including over the counter medicine, during school hours, you have the following choices:

1. You may use the school's "Permission for Medication" form and have your doctor indicate on the form the drug, dose, time to be given and possible side effects.
 - a. In addition, the medication must be: in a pharmacy labeled bottle containing instruction; provided to the school by the parent; and parent agrees to assume all responsibility for maintaining the supply of medication and replacing as needed.
2. You may discuss with your doctor an alternative schedule of medication so it can be given outside of school hours.
3. You may come to the school and give it to your child at appropriate times.

These policies must be strictly followed to ensure the safety of your child and the well being of all students. We appreciate your cooperation in this matter.

STUDENT NAME _____ **DOB** _____

SCHOOL _____ **GRADE** _____

PHYSICIAN USE ONLY	
MEDICATION _____	DOSAGE _____
PURPOSE OF MEDICATION _____	
TIME OF DAY MEDICATION IS TO BE GIVEN _____	
POSSIBLE SIDE EFFECTS _____	

PHYSICIAN NAME _____	PHONE _____
<small>(Please Print)</small>	
PHYSICIAN SIGNATURE _____	DATE _____
<small>The above signed physician advised you that your student requires the described medication during the school day.</small>	

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by the Delta School District 50J, the undersigned parent hereby agrees to release the Delta County School District 50J and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other consequences of the medication.

I hereby give my permission for _____ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication.

PARENT SIGNATURE _____ **DATE** _____

SCHOOL NURSE SIGNATURE _____ **DATE** _____