Sargent School District RE-33J
Office of the School Nurse
7090 N. Rd. 2 E.
Monte Vista, CO 81144
Phone # (719) 852-4024
Fax # (719) 852-0399

Permission for Medication Administration at School

I hereby request and give permission to the school nurse or other authorized school personnel to administer the following medication/treatment to this child.

Name of Student: _____

Grade: _____ Teacher: _____

Medication: _____

Dosage, Route, and Time: _____

Purpose of Medication: _____

Specific Instructions: _____
If this is a MDI, please include specific instructions (such as "prior to P.E.", "prior to recess", or "prior to athletic practice and events").

Start Date of Medication: _____

If limited medication, give last date medication should be administered. _____

NOTICE: SHOULD A CHANGE IN ANY OF THE ABOVE INFORMATION OCCUR, A REVISED WRITTEN PHYSICIAN ORDER MUST BE SUBMITTED.

MEDICATION MUST BE BROUGHT TO THE SCHOOL NURSE OR SECRETARY IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY OR PHYSICIAN AND MUST BE LABELED WITH STUDENT NAME, MEDICATION, DOSE, ROUTE, TIME, AND PRESCRIBING PHYSICIAN'S NAME. (Some pharmacies will give an extra labeled bottle to the parent if asked for for school administration.)

It is the responsibility of the student to come to the nurse's office each time for medication unless he/she is physically unable to do so.

_____ _____
Physician Signature Date

_____ _____
Parent Signature Date

I hereby give the school nurse permission to discuss this specific medication/treatment with my child's prescribing and primary physicians.

_____ _____
Parent/Guardian Signature *Date*