Sargent School District RE-33J
7090 North Road 2 East
Monte Vista, CO. 81144
719-852-4024

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 medications/treatments to this student

Name of Student:_____

Grade:_____ Teacher:_____

Medication:_____Purpose of Medication:_____

Dose, Route and Time:_____

Instructions:_____
If this is a MDI, please include specific instructions (such as “prior to PE”, “prior to recess”, or “prior to athletic practice/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.

Medications 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, TIE 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 the student is physically unable to do so.

_____ _____
Physician Signature/Date Parent Signature/Date

I hereby give the school permission to discuss this specific medication/treatment with my child’s prescribing and primary care physician.

_____
Parent Signature/Date