North Conejos School District RE1-J

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Phone (719) 274-5174
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OFFICE OF THE SUPERINTENDENT

Permission for Medication

Name of Student_____

School_____Grade_____

Teacher_____

Medication_____Dosage_____

Purpose of Medication_____

Anticipated number of days it needs to be given at school_____

Date_____ _____

Signature of Physician

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 the school nurse or other designee employed by the North Conejos School District, the undersigned parent/guardian hereby agrees to release the North Conejos School District and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication.

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

Date_____ _____

Signature of Parent/Guardian