BOULDER VALLEY SCHOOL DISTRICT RE-2
SCHOOL HEALTH PROGRAM

MEDICATION ADMINISTRATION AUTHORIZATION

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  ___________________ 20___________.

__________________________________________   _______________________________________
Name of Physician or Dentist       School child attends
prescribing medication

__________________________________________________________   __________________________
Physician’s Signature           Date

For inhalers & EpiPens only: 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

2.5

Rev. 04/02