

**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  
prescribing medication

\_\_\_\_\_  
School child attends

\_\_\_\_\_  
Signature of Parent or Guardian

**PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL**

Student's Name \_\_\_\_\_ Medication \_\_\_\_\_

Route of administration \_\_\_\_\_ Dosage (total mg/dose) \_\_\_\_\_

to be given at \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_  
(time) (date) (date)

Purpose of medication \_\_\_\_\_

Possible side effects \_\_\_\_\_

\_\_\_\_\_  
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**