Trinidad School District JLCD-E

Permission for Medication

Name of student_____

School_____ Grade_____

Medication_____ Dosage_____

Purpose of medication_____

_____

Time of day medication is to be given_____

Possible side effects_____

_____

Anticipated number of days it needs to be given at school_____

Date_____ _____

Signature of health care practitioner

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by the Trinidad School District the undersigned parent or guardian hereby agrees to release the Trinidad 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 medication
Name of Student
at school as ordered. I understand that it is my responsibility to furnish this medication.

A new Permission for Medication form must be completed for each medication change and each school year.

_____
Parent/guardian printed name

_____ _____
Parent/guardian signature *Date*

Revised June 2021
Adopted Sep. 2010