



# Creede School District

## **Permission for Medication** All Medications Including Inhalers

Name of Student \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Teacher \_\_\_\_\_

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 Physician

Extra Instructions \_\_\_\_\_

\_\_\_\_\_

I hereby give my permission for \_\_\_\_\_ to take the above prescription at school as ordered, and release Creede School District from the responsibilities pertaining to side effects of this medication.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Parent or Guardian

Note: The prescription medication is to be brought to school in a container appropriately labeled by the pharmacy, or physician, stating the name of the medication and the medication and the dosage.