

BOULDER VALLEY SCHOOL DISTRICT RE-2 / BOULDER COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH PROGRAM

PARENT'S REQUEST FOR GIVING MEDICINE AT SCHOOL
And
RELEASE AGREEMENT AND PHYSICIAN'S SIGNED ORDER

The undersigned parent(s) or guardian(s) of _____ hereby request
personnel employed by either the Boulder Valley School District Re-2 or the Boulder County Health
Department to see that said child receives _____
(name of medicine)
at _____ as described below by prescribing physician.
(time)

It is required by the Boulder Valley School district and the Boulder County Health Department 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 name, 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 either the Boulder Valley School District Re-
2 or the Boulder County Health Department, the undersigned parent(s) or guardian(s) hereby agree(s) to release
the said institutions 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 administration _____ Dosage _____ to be given at _____
(time)
from _____ to _____
(date) (date)

Purpose of medication _____

Possible side effects _____

Physician's signature _____ Date _____

**For inhalers & Epi-pens only... Doctor, please sign below to give permission for student to carry and self-administer the
inhaler and Epi-pen ordered on this form.**

Physician's signature & date