Elizabeth SCHOOL DISTRICT

# PROVIDER MEDICATION AUTHORIZATION FORM
## 20____ - 20____

Student Name: _____ DOB: _____ School: _____

**TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY:**

| Name of Medication | Reason for Medication | Medication Dosage and Strength | Route | Time(s) Medication to be given/and for how long | Possible Side Effects |
|---|---|---|---|---|---|
| | | | | | |
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Healthcare Provider's Signature: _____ Date: _____

Healthcare Provider's Name: _____ Phone: _____

Elizabeth School District Policies JLCD and JLCD-R require, as a condition to its agreement to permit the administration of medication at school or school-sponsored events, that the medicine be prescribed by a healthcare provider with prescriptive authority under Colorado law. The medication(s) must be provided by the parent(s) of the student with the original pharmacy container label stating the student's name, name of the medication, the dosage, the number of doses per day or time(s) when the medication is to be released to the student, and the date when the medication is to be stopped (if applicable), and the indications for use.

It is understood that the Medication will be administered solely at the request of, and as an accommodation to, the undersigned parent(s)/guardian(s). The undersigned parent(s)/guardian(s) hereby agree(s) to exempt and release the Elizabeth School District, its directors, officers, employees, volunteers, and agents from any and all liability, claims, demands or actions arising out of any damage, loss, or injury that my child or I/we sustain from my/our child arising out of the administration of the above procedure(s).

Parent/Guardian Signature: _____ Date:_____

School Nurse Signature: _____ Date:_____