GUNNISON WATERSHED SCHOOL DISTRICT RE – IJ

PERMISSION FOR MEDICATION – Lake School

Name of student:_____

School:_____ Grade:_____

Teacher:_____

Medication:_____ Dosage_____

Purpose of Medication:_____

_____

Time of day medication is to be given:_____

Anticipated number of days it needs to be given at school_____

_____ _____

Name of Physician Fax #

_____ _____

Signature of Physician Date

I hereby give my permission for_____ to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication.

_____ _____

Signature of Parent/Guardian Date

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 dosage.

2016-17