

**GUNNISON WATERSHED SCHOOL DISTRICT RE – IJ**

**PERMISSION FOR PRESCRIBED MEDICATION**

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.