DENVER PUBLIC SCHOOLS
Division of Student Services
Nursing Services 2007/2008

School ____________________

Phone ____________________

FAX ____________________

STUDENT MEDICATION REQUEST RELEASE AGREEMENT

The undersigned parent(s) or guardian(s) of:

Name of Student ______________________________ **Date of Birth** ___/___/___ hereby request

personnel employed by the Denver Public School District to release to said child

Name of Medication: ______________________________ at (Time given at School) ____________

as described by the prescribing physician.

In compliance with School District Policy JLCD- Administering Medicines to Students, which requires as a condition to its agreement to release any medication, that the medicine has been prescribed by a physician or dentist and that it has been furnished by the parent(s) of the student with the original pharmacy container label stating the child's name, name of the medication, the dosage, the number of dosages 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). It is understood that the medication is given solely at the request of and as an accommodation to the undersigned parent(s) or guardian(s). The undersigned parent(s) or guardian(s) hereby agree(s) to release the Denver Public Schools and its personnel from any and all claim(s) which they now have or may hereafter have arising out of the release of, or failure to release, the medication to the student. At no time did any school member recommend or require the student be prescribed psychotropic medication(s) to attend school.

______________________________ ____________________
(Signature of Parent or Guardian) (Month/Day/Year)

PHYSICIAN'S SIGNED ORDER FOR MEDICATION

This form must be completed for any medication a student will need to take during school hours.

Student's Name: ______________________ Grade: __________ Date of Birth ____/____/____

Medication Name: ______________________________ Dosage: ______________

Route: ______________ Frequency: ______________ Times given at School: ________

To be administered from Date: ___/___/___ to ___/___/___

Purpose of Medication: ______________________________

Possible Side Effects: ______________________________

______________________________ Phone: ______________ FAX: ______________
(Print) Name of Physician or Dentist Prescribing Medication

______________________________ Date: ___/___/___ Clinic: ______________
(Physician's Signature)

Medication Discontinued: Time ______ and Date ___/___/___ Physician's Signature ______________

7/07