STUDENT MEDICATION REQUEST AND RELEASE AGREEMENT

To Be Completed By Parent

The undersigned parent(s) or guardian(s) of _____ hereby request personnel employed by the Douglas County School District RE-1 to release to said student (name of medicine) _____ as described below by the prescribing physician.

School District Policy JLCD requires, as a condition to its agreement to release any medication, that the medicine be prescribed by a physician or dentist and furnished 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 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 Douglas County School District RE-1 and its personnel from any and all claim(s), which they now have or may hereafter have arising out of the release of the medication to the student.

Parent or Guardian Signature:		**Date:**		**School student Attends:**	
Physician/ Dentist Prescribing Medication:		**Physician's/Dentist's Telephone Number:**			

This form must be completed for any medication (*prescription or non-prescription FDA approved)* a student will need to take during school hours. A new Student Medication Request and Release Agreement form must be completed for each medication change and each school year.

To Be Completed By Health Care Provider
School Year: _____

All medication orders end with the school year and new orders must be submitted for each school year. The undersigned requests that the above-listed medication be released to the student in accordance with these instructions:

Student Name: _____DOB: _____

Diagnosis/Purpose: _____ **If for allergies, please list: _____**

Medication Name	**Start Date**	**End Date**	**Dose in *milligrams/ micrograms***	**Route**	**Time to be given**	***If PRN,* specify: When indicated (signs/symptoms) Frequency of administration Please note if inhaler can be repeated sooner than indicated**	**Side Effects to be reported:**
			mg/mcg				
			mg/mcg				
			mg/mcg				

Name and Title of Licensed Prescriber (Please Print) _____

Prescriber's Signature_____ Date_____

☐ Reviewed/Complete ☐ Need Clarification

School Nurse Signature: _____ Date:_____

Health Services
Revised 3/21/2014