POUDRE SCHOOL DISTRICT
Health Services
2407 LaPorte Ave
Fort Collins CO
80521

Authorization and Release

For Administering Medicine to Student at School or School-Sponsored Activity

A separate written Authorization and Release must be submitted each school year for each medicine to be administered to a student, and for each change in the dosage, time(s) and/or route of administration.

**** This form is NOT to be completed for medical marijuana use**.

[Parent Completes]

Student Name: _____ **Student ID#:** _____

Date of Birth: _____ **Grade:** _____ **School Year:** _____

School Student Attends: _____ **Fax Number:** _____

School/Activity where Medicine is to be Administered: _____

[Health Care Provider Completes]

Health Care Provider Authorization and Directions

Name of Medicine: _____

The Medicine is: ☐ Prescription ☐ Nonprescription

Purpose of Medicine: _____

Dosage: _____ Route of Administration: _____

Time(s) the Medicine is to be Administered: _____

Starting Date: _____ Ending Date: _____

(All Authorizations expire July 31st of the current year)

Possible Side Effects of Medication: _____

Printed Name of Health Care Provider: _____ Office Phone: _____

Signature of Provider: _____ Date: _____

Special Instructions

Prescription Medication: Must be furnished in the original pharmacy labeled container. The student's name, name of the medicine, dosage, name of prescribing health care provider (who is required to furnish Health Care Provider Authorization and Directions above), date prescription was filled, and expiration date must be printed on the medicine container's pharmacy label.

Nonprescription Medication: Must be furnished in the original container labeled by the pharmaceutical company or other commercial distributor of the medicine.

[Parent Reads and Signs]

Parent/Guardian Request, Permission and Release

I hereby request and give my permission for Poudre School District R-1 to administer to my child the medicine named in the above Health Care Provider Authorization and Directions, as specified by the health care provider. In connection with my request, I hereby authorize the health care provider to provide information to School District personnel who may be involved in administering the medicine to my child. If my request is granted (as noted by the employee signature in the PSD Authorization below), I hereby release and hold harmless the School District and its board members, employees and agents from any and all liability, claims, causes of action, damages and demands of any kind whatsoever (except willful and wanton acts or omissions) that may be brought by my child or on my child's behalf for any and all damages, including personal injury to my child, arising out of or in connection with the administering of medicine to my child as provided above.

Signature of Parent/Guardian: _____ Date: _____

PSD Authorization:

Employee Signature: _____ Date: _____