

**DOUGLAS COUNTY SCHOOL DISTRICT Re. 1  
SCHOOL HEALTH SERVICES**

**STUDENT MEDICATION REQUEST AND RELEASE AGREEMENT**

This form must be completed for any medication (prescription or non-prescription) a student will need to take during school hours.

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) \_\_\_\_\_ at (time) \_\_\_\_\_ 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.

A new Student Medication Request and Release Agreement form must be completed for each medication change and each school year.

\_\_\_\_\_  
(Parent or Guardian Signature) (Date)

\_\_\_\_\_  
(School Student Attends)

\_\_\_\_\_  
(Physician or Dentist Prescribing Medication) (Physician's or Dentist's Telephone Number)

------(Do Not Cut)-----

**PHYSICIAN'S SIGNED ORDER FOR MEDICATION**

The undersigned requests that the above-listed medication be released to the student in accordance with these instructions:

Student's Name \_\_\_\_\_ Medication \_\_\_\_\_

Route of Administration \_\_\_\_\_ Dosage \_\_\_\_\_ Time/Frequency \_\_\_\_\_

Start Date \_\_\_\_\_ Discontinue Date \_\_\_\_\_  
(All medications expire at end of school year.)

Purpose of Medication(s) \_\_\_\_\_

Side Effects of Particular Concern: \_\_\_\_\_

\_\_\_\_\_  
(Physician's Signature) (Date)

Modified: August 18, 1992; July 20, 1999; April 4, 2006; May 16, 2006

Douglas County School District Re. 1, Castle Rock, Colorado