



**GUNNISON  
WATERSHED  
SCHOOL DISTRICT**  
Driven to Be the Difference

**PERMISSION TO ADMINISTER MEDICATION DURING SCHOOL HOURS &  
SCHOOL SPONSORED ACTIVITIES, 2022-2023 SCHOOL YEAR**

Name of student: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Route: \_\_\_\_\_ Time(s): \_\_\_\_\_

If 'as needed' (PRN), indicate when dose can be repeated: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Anticipated number of days the medications needs to be given at school \_\_\_\_\_

\_\_\_\_\_  
Name of Physician Fax #

\_\_\_\_\_  
Signature of Physician Date

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by GWSD, the undersigned parent or guardian hereby agrees to release GWSD and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication. I give my permission for school staff to contact the prescribing provider regarding this medication.

I hereby give permission for \_\_\_\_\_ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication

\_\_\_\_\_  
Signature of Parent/Guardian Date

Note 1: The prescription medication is to be brought to school in a container appropriately labeled by the pharmacy or healthcare practitioner stating the name of the medication and the dosage.

Note 2: Those personnel administering medications are trained in observing for side effects and in the appropriate steps to take should side effects occur. While the school is not responsible for the occurrence of side effects, the school is responsible for observing for side effects.