

Superintendent File: JLCD-E-1

STUDENT PRESCRIPTION AND OVER-THE-COUNTER MEDICATION REQUEST AND RELEASE AGREEMENT

Student Name: _____ **DOB:** _____ **School Year:** _____

Medication: _____
(Signed Health Care Provider Medication Order must be attached)

School District Policy JLCD requires, as a condition to its agreement to release any prescription or over-the-counter medication, that the medicine be prescribed by a healthcare provider with prescriptive authority **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 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/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Revised: September 20, 2016

Revised: August 24, 2017

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At the end of the school year, I/we would like the medications to:

_____ Go Home with my Student on the last day of school

_____ Parent/Guardian will pick up the last week of school

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____