Authorization and Release
For Administering Medication 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.

[Parent Completes]

Student Information

Student Name _____ ID# _____

Date of Birth _____ Grade _____ School Year _____

Please return form to Resurrection Christian School Fax 970 647 7385

School/Activity Where Medicine is to be Administered Resurrection Christian School and/or Field Trips

[Health Care Provider Completes]

Health Care Provider Authorization and Directions

Medication _____ ☐ PRESCRIPTION ☐ NONPRESCRIPTION

Purpose of Medication _____

Dosage _____ Route _____ Time(s) the Medication is to be Administered _____

Starting Date _____ Ending Date _____

(All authorizations expire May 31st of the current year)

Possible Side Effects of Medication _____

Health Care Provider Name _____ Office Phone _____

(Please Print)

_____

Health Care Provider Signature (MD/DO/NP/PA) Date

Special Instructions

Prescription Medication: Must be supplied in original pharmacy labeled container.
NOTE: The student's name, medication name, dosage, prescribing health care provider name (who is required to provide Health Care Provider Authorization and Directions above), date prescription was filled, and expiration date must be printed on the pharmacy label on the medication container.
Nonprescription Medication: Must be supplied in the original container/packaging labeled by the pharmaceutical company or other commercial distributor of the medication.

[Parent Reads and Signs]

Parent/Guardian Request, Permission and Release

I hereby request and give my permission for Resurrection Christian School to administer to my child the medicine named in the above Health Care Provider Authorization and Directions, as specified by my Health Care Provider. In connection with my request, I hereby authorize the health care provider to provide information to RCS 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 RCS Authorization below), I hereby release and hold harmless RCS 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 medication to my child as provided above.

_____

Parent/Guardian Signature Date

RCS Authorization

_____

Employee Signature Date