

Permission for Medication

Junior Docent Name: _____ Birthdate: _____

Primary Health Care Provider: _____

Medication: _____

Dosage: _____ Route: _____

Time of day medication is to be given: _____

Purpose of medication: _____

Possible side effects: _____

Anticipated number of days medication will need to be given: _____

I authorize the above listed student to self-administer the medication listed on this form
(circle): YES NO

Signature of Prescribing Authority: _____ Date: _____

Parent/Guardian

I hereby give permission for the above listed student to take the above prescription medication as indicated. I understand that it is my responsibility to furnish this medication. I authorize the above listed student to self-administer the medication listed on this form.

Signature of Parent/Guardian: _____ Date: _____

Note: The medication is to be brought to the site in its original container, appropriately labeled by the pharmacy or person with prescriptive authority, along with this copy of the medication order. Staff will not administer medications.

A separate completed form is required for each medication.



Colorado Springs
PIONEERS MUSEUM

