

Student Medication Administration Form

Parents are encouraged to administer medication to their children outside of school hours if at all possible. Only medications that are required to enable a student to stay in school may be given at school. If necessary, medications (prescription or over the counter) can be given at school under the following conditions:

1. All medications must be ordered by providers with prescriptive authority in Colorado (MD, DO, NP, PA).
2. All medication forms must be renewed each school year.
3. Written permission by parent and physician in all cases.
4. Medications must be in the original, properly labeled container. Medications sent in baggies or unlabeled containers will not be given.
5. All medications must be kept in the health room. Self-carry medications need to be evaluated by the school nurse.
6. **Emergency asthma or allergy medication** may be carried and self-administered by a responsible student as determined by the school nurse. A written contract is required between student, parent, physician and school nurse. Please contact your school nurse for information on the contract.

✓ The information/form below must be completed and signed by the health care provider.
✓ In addition, the medication bottle must match the prescription as written below.

STUDENT NAME: _____
 First Name Last Name
SCHOOL: _____ GRADE _____ DOB _____
MEDICATION: _____ DOSAGE: _____
TIME TO BE GIVEN: _____ ROUTE: _____

✓ If PRN, (as needed) please note the minimum duration time between doses
✓ If medication is an inhaler, insulin, anticonvulsant or epipen, student also needs a Health Care plan signed by provider.

Anticipated time frame: (Must be renewed each school year)
This form expires: (1) at the end of the Calendar School Year: _____ or
(2) specific time frame: from _____ to _____

Date: _____ Physician/PA/NP Signature: _____
Physician/PA/NP Printed Name: _____
Physician/PA/NP Phone Number: _____

I hereby give permission for _____ to take the above prescription at school as ordered by the Health Care provider. I understand that it is my responsibility to furnish this medication. Acetaminophen and Ibuprofen may be provided in the health office, please contact school nurse if any concerns on product. I also understand that all medications must be transported to and from school by a parent/guardian or approved emergency contact person. By signing this document I release the school health authority for responsibilities pertaining to possible side effects and give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

Date: _____ Parent/Guardian Signature _____

