Englewood Schools
Medication Administration in School or Child Care

The parent/guardian of ______________________ **ask that school staff give the following**
Child's Name

medication ______________________ **at** ______________
Name of Medicine and Dosage / Time(s)

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is meant to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label. **Over the counter medication** must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

The School agrees to administer medication prescribed by a licensed health care provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff.

The Parent/Guardian understands that they will be notified to pick up medications if the medication is expired, the school year ends, or the student withdraws. All student specific medication(s) that are left at the school will be discarded according to the Colorado Board or Pharmacy recommendations.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or a school staff delegated to administer medication.

Parent/Legal Guardian Name ______________ Parent/Legal Guardian Signature ______________ Date ______________

Work Phone ______________ Home Phone ______________

Health Care Provider Authorization

Child's Name: ______________________ Birthdate: ______________

Medication: ______________________ Route: ______________

Dosage: ______________ To be given in a school at the following time(s): ______________

IMPORTANT: Additional paperwork - signed by your Health Care Provider - is required for Asthma, Severe Allergies, or Seizures.

If the medication is prn (as needed), please describe symptoms to administer the medication and intervals between dose:

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Special Instructions: ______________________

Purpose of medication: ______________________

Side effects that need to be reported: ______________________

Starting Date: ______________ Ending Date: ______________

Signature of Health Care Provider with Prescriptive Authority ______________ *License Number* ______________

Print Name of Health Care Provider ______________ *Phone Number* ______________ *Fax Number* ______________

SELF-CARRY SECTION

This student has been instructed and is capable of self-administering the medication.
This student may carry their: Medication (list) ______________________

Signature of Health Care Provider with Prescriptive Authority ______________ *Date* ______________

I understand a written contract will be developed between the school nurse, the student and the parents/legal guardian to establish levels of responsibilities for each individual.

Parent/Legal Guardian's Name ______________ *Parent/Legal Guardian's Signature* ______________ *Date* ______________

Please ask the pharmacist for a separate medicine bottle to keep at school/child care. Thank you!