Widefield School District 3
Standard Medication Form

Student Name: _____ _____ Date of Birth: _____
(First Name) *(Last Name)*

School: _____ Grade: _____

Parents are encouraged to administer medication to their children outside of school hours if at all possible. Only medications which are required to enable a student to stay in school may be given at school. Prescription medication and FDA approved over-the-counter medication may be administered to students by the school nurse or other school designee only when the following requirements are met:

1. The school shall have received signed, written permission to administer the medication from the student's health care practitioner with prescriptive authority under Colorado law. Medication orders must be renewed at the beginning of every school year at a minimum.
2. The school shall have received signed, written permission from the student's parent/guardian to administer the medication to the student.
3. The parent/guardian shall be responsible for providing all medication to be administered to the student.
4. Medication shall be in the original properly labeled container. Medication sent in baggies or unlabeled containers will not administered at school.
5. Any changes to medication, dosage, route, purpose or symptoms to be given for or time to be given require a new medication order.

I hereby give permission for Widefield School District 3 to administer my child the following prescription medication listed below to my child at school as ordered by the Health Care provider. I understand that it is my responsibility to furnish this medication. 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 hereby release Widefield School District 3, its Board members, employees and agents from any and all liability damages or claims arising from or in connection with any adverse drug reaction or side effects suffered by my child as a result of administering the medication listed on this form.

_____ _____ _____ _____
Parent/Guardian Signature Date School Nurse Signature Date

- ✓ **The information/form below must be completed and signed by the physician.**
- ✓ **The medication label must match the prescription as written below**.
- ✓ **If PRN, (as needed) please note the minimum duration time between doses.**
- ✓ **If medication is an inhaler, insulin, anticonvulsant or epipen, provider signature must be on the appropriate form.**

Physician Use Only

Student Name: _____ _____ Date of Birth: _____
(First Name) *(Last Name)*

Medication: _____ Purpose of Medication: _____

Exact Dosage (No Ranges): _____ Administration Time: _____

Minimal Interval Between Doses: _____ Route: _____

Possible Side Effects: _____

Time Frame: School Yr. _____ – _____ OR From: _____ To: _____
(mm/dd/yyyy) *(mm/dd/yyyy)*

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

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