SCHOOL MEDICATION ADMINISTRATION & HEALTH FORM

Dear VMS Parent:

The *School Medication Administration & Health Form* on the following pages must be completed for students who have a health condition(s) or who will need to take any type of medication at school.

Student Health Conditions

- Students with a LIFE-THREATENING ALLERGY, ASTHMA, SEIZURES OR OTHER HEALTH CONDITION must submit an applicable Action Plan(s) and the *Medication Administration & School Health Form* in their entirety.
- Students with a condition that is not life-threatening, but requires medication to be taken at school or on field trips must submit a completed *Medication Administration & School Health Form* in its entirety.
- Students with a minor condition that staff should know about, but that requires no action or medication, must complete Part 2 and Part 3 of the *Medication Administration & School Health Form*.

Part 1 must be completed and signed by a physician for prescription and/or over the counter medication, including but not limited to Advil, Tylenol, Benadryl, anti-itch cream, or antibiotic ointment. Part 2 must be completed and signed by the parent/guardian. Part 3 is to be signed by the parent and the student after the physician has authorized a student to self-carry/self-administer a medication in Part 1.

This *Medication Administration and School Health Form* from and medical action plans need to be updated yearly; **forms from previous years are not valid** per medial administration laws. **The school will not accept paper or emailed copies of the form(s); parents must upload them to PCR during the back-to-school process in August in a PDF format.** It is advised that parents keep an electronic version of the forms for upload to PCR. Similarly, do not have the doctor's offices fax them to school; parents must electronically upload them.

Medications

- Medication should be **hand-delivered** to the front desk on or before the first day that your child participates in any VMS activities, including orientation trips. Per State of Colorado law, parents will be asked to sign the medication intake form in order for the school to accept the medication.
- Never place medication into a child's backpack unless they have permission to self-administer from their physician.
- Any medicine (prescription or over-the-counter) must be in the original container and labeled with your child's name.

Thank you.

2021-22 School Medication Administration & Health Form

Student Name: _____ Grade: _____ Birthdate: _____ Homebase: _____

Parent/Guardian Name: _____ Parent/Guardian Phone: _____

PART 1: Healthcare Provider Permission to Administer Medication in School

Required by Colorado law for <u>all prescription or over the counter medications</u>

Healthcare Provider Authorization to Administer Medication in School *(to be completed by the medical provider)*				
Student's Name:		**Birthdate**		**Grade:**
Medication	**Medication 1**	**Medication 2**	**Medication 3**	**Medication 4**
Dosage:				
Route (oral, etc.):				
Time(s) to be given:				
Start Date & End Date:				
Reportable side effects				
Special instructions				
Indication for medication				
Student may self-carry	___ No ___Yes	___ No ___Yes	___ No ___Yes	___ No ___Yes
Student may self-administer	___ No ___Yes	___ No ___Yes	___ No ___Yes	___ No ___Yes
Mediation is needed on a field trip?	___ No ___Yes	___ No ___Yes	___ No ___Yes	___ No ___Yes
Medication will be brought from home or taken from the VMS infirmary?	___ Home ___Infirmary	___ Home ___Infirmary	___ Home ___Infirmary	___ Home ___Infirmary

Healthcare Provider Name_____ Healthcare Provider Signature_____

License Number _____ Healthcare Provider Phone: _____ Date: _____

PART 2: Parent/Guardian Authorization

I_____, parent/guardian of _____ give permission for VMS staff to share information, administer the listed medication, care for my child, and, if necessary, contact the healthcare provider on record according to the healthcare provider's signed instructions. I understand that VMS staff can **only** administer medication (whether over-the-counter or prescription) **<u>if my licensed healthcare provider has signed and authorized this form.</u>**

Per the Colorado Nurse Practice Act, the parent/guardian must **furnish medicine to the school and pick up expired or unused medication** within one week or medication will be disposed. Medication is sent home the last week of school unless it is a controlled substance or an Epi-pen.

Prescription medications and/or over-the-counter medications must come with a doctor's order, parent permission, and must come in the original container. **Prescriptions must come** in the original container with the child's name, name of medicine, time medicine is to be given, dosage, the date medicine is to be stopped, licensed health care provider's name, pharmacy name and phone number. **Over-the-counter** dosage must match the signed health care provider authorization, and medicine must be packaged in the original container. *Note: A Health Care Plan, such as an Asthma Action Care Plan or Allergy and Anaphylaxis Plan, may also be required to be on file.*

Sharing information: By signing this, I give permission for the school staff to communicate with the health care provider(s), pharmacy, or other appropriate person/clinic regarding this student's medical condition or medication by phone, fax, email or scan on issues regarding dosing, student's refusal to take meds, side effects, reports of suicidal thoughts, etc. It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian.

Field Trip Health Concerns and Medication Administration

If your student regularly takes any medication that would need to travel along with him/her or be given to him/her on field trips, OR if your child has another type of health condition that teachers need to be aware of, please complete the following.

My child has the following condition for which medicine is required on a field trip: _____

_____

_____

Release of Liability: In consideration of the acceptance of the request to perform this service by the school staff, the undersigned parent/guardian hereby agrees to release VMS and its personnel from any legal claim which they now have or may hereafter arise out of side effects or other medical consequences of the medication.

I hereby give my permission for the above student to take medication as ordered.

Parent/Guardian's Name_____ Parent/Guardian Signature_____

Work phone: _____ Cell Phone: _____ Date: _____

PART 3: Permission to Self-Carry/Self-Administer Medication at School

Middle School & Upper School students

School/Activity where medicine is to be administered: _____

Name of Medicine(s): _____

Special Instructions:

The student is only authorized to carry and self-administer one-day dose of medicine at school or at a school-sponsored activity as specified above unless more than a one-day dose is necessitated by the length of the school-sponsored activity or the type of medication. The student shall at all times maintain the security of his or her medicine so that it may not be taken by or fall into the possession of another person.

Parent/Guardian Request, Permission and Release

I hereby request and give my permission for Vail Mountain School to allow my child to carry and self-administer the medicine named above. I hereby authorize the healthcare provider to provide information to VMS personnel who may be involved in determining if my child will be authorized to carry and self-administer the medication.

I hereby release and hold harmless VMS 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 my child carrying and self-administering the medicine as provided above.

Parent/Guardian Signature: _____ Date: _____

Student Acknowledgement

I acknowledge that carrying and self-administering medicine at school or a school-related activity is a privilege that may be lost if not exercised responsibly and safely as determined by VMS personnel, and that the authorization for me to carry and self-administer the medicine noted above may be revoked at any time if I fail to comply with the expectations set forth here.

Student Signature: _____ Date: _____

PRESCRIPTION MEDICATION must have:	**OVER THE COUNTER MEDICATION** must have: (Tylenol, Advil, anti-itch cream, antibiotic ointment, Benadryl)
• Original pharmacy labeled container with name & phone # • Student's name • Medication name • Dosage • Frequency • Licensed healthcare provider's name • Expiration Date	• Original container • Labeled with your child's name • Dosage consistent with your health care provider's authorization (above)

CCHC/SN/MAT STAFF Signature: _____ Date: _____