# Englewood Schools Medication Administration in School

**The parent/guardian of** _____ **ask** _____ **give the following**
*Child's Name and Grade* *School's Name*

**medication:** _____ **at** _____
*Name of medication 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 first and last 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*

_____ _____
*Home/Cell Phone.* *Work Phone*

## Health Care Provider Authorization

| | | |
|---|---|---|
| Child's Name: | | Birthdate: |
| Medication: | Dosage: | Route: |
| To be given at the following time(s): | Start Date: | End Date: |
| Special Instructions: | | |
| Purpose of Medication | | |
| Side Effects to be reported: | | |

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

If the medication is PRN (as needed), please describe the symptoms to administer the medication and intervals between doses.

HEALTH CARE PROVIDER

_____ _____
*Signature of Health Care Provider with Prescriptive authority.* *License Number*

_____ _____ _____
*Printed 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) _____

HEALTH CARE PROVIDER _____ _____
*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*

*School Nurse Signature:*_____ *Date:* _____

Revised: 8/2018