School District 27J
18551 E. 160th
Brighton, CO 80601
(303) 655-2900

Permission for Medication Administration at School

The parent/guardian of _____asks that properly trained and delegated school staff give
Child's Name
the following Medication _____at _____to my child according
Name of Medication and Dosage *Time(s)*
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, dosage, time medicine is to be given, date medicine is to be stopped and licensed health care provider's name, pharmacy name and phone number. Medication must be packaged in an original container from the pharmacy.
Please ask the pharmacist for a separate, labeled container to remain at school. Thank you!

Over the Counter medication must be labeled with child's name. Dosage on the container **must** match the signed health care provider authorization. Medicine must be packaged in original container.

The school center agrees to administer medication prescribed by a health care provider with prescriptive authority. It is the parent/guardian's responsibility to provide the medication. The parent agrees to pick up expired or unused medication per school's policy. All medication left at school will be discarded according to the most current state regulatory recommendations for safe medication disposal.

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 school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name (PRINT) Parent/Legal Guardian (SIGNATURE) Date

_____ _____ _____
Work Phone Home/Cell Phone School Name & Fax Number

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Health Care Provider Authorization

Do not use medical abbreviations. Use exact doses and times, if applicable. We cannot accept a range doses or a range of times to be given.

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

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

_____ _____/_____
Printed name of Health Care Provider **Phone & Fax Number**

_____ _____
Signature of School Nurse or Child Care Health Consultant **Date**