Adams 12 Five Star Schools

PARENT/LEGAL GUARDIAN'S RELEASE FOR ADMINISTRATION OF MEDICATION OR PROCEDURE AT SCHOOL AND AUTHORIZED PRESCRIBER SIGNED ORDER

Health Services

The undersigned **parent/legal guardian** of _____, Date of Birth _____/_____/_____, hereby requests personnel employed by Adams 12 Five Star Schools to administer or supervise administration of medication or a procedure as ordered by an authorized prescriber. **This is effective for the current school year.**

It is required by Adams 12 Five Star Schools, as a condition to its agreement to administer any medication, that the medication be prescribed by a licensed physician either MD or DO, dentist, physician assistant (PA), advanced practice registered nurse (NP), or other authorized prescriber; and that it will be furnished by the parent/guardian of the student in a container dispensed by a pharmacy or in an original over-the-counter container which is labeled with the student's name, medication name, dosage, and time when the medication is to be given. It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. The undersigned parent/guardian hereby agrees to release Adams 12 Five Star Schools and its personnel from any and all claim(s), which they now have or may hereafter have to arise out of the administration of, or failure to administer, the medication to the student. By signing this release, I hereby authorize employed personnel of Adams 12 Five Star Schools to contact the authorized prescriber, if necessary, to clarify any written order. The medication will be administered by Adams 12 Five Star Schools personnel according to the authorized prescriber's written order/treatment plan, parent permission, and as specified in District Policy 5420.

School: _____ Phone: _____ Fax: _____

PARENT Signature: _____ Date: _____

Attention Prescribers: If this is for a <u>RESCUE INHALER OR EPI-PEN</u>, complete the "Colorado Asthma Care Plan and Medication Orders" form or the "Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders" form.

Student Name:_____ DOB:____/____/____

Medication Name: _____

Medication Dosage:

1. _____ MG Tablets/Chewable/Capsules/Liquids/Ampules

OR

2. Inhaler:_____ puffs (for medication other than rescue inhaler)

Medication Route:
☐ Oral ☐ Topical ☐ Rectal ☐ IM ☐ Inhaled ☐ Nebulizer ☐ G-tube

Procedure: ☐ Catheterization ☐ Pulse Oximetry ☐ Other: _____

Procedure Details: _____

Time to be given: _____

May be repeated every: _____

Special instructions: _____

_____

Start Date: _____

Stop Date: _____

OR

☐ End of School Year
(A new authorization is needed at the beginning of each school year)

Purpose:

Possible Side Effects:

Other Comments:

PRINTED NAME of Authorized Prescriber:_____

Authorized Prescriber Signature:_____ Date: _____

Office Address: _____ City: _____ Zip: _____

Office Phone: _____ Office Fax: _____

School Nurse Signature: _____ Date: _____

(Rev 11/23)