Carry and Self-Administer Prescribed Medicine at School or School-Sponsored Activity

to treat asthma, severe allergies or other life-threatening conditions at school, school-sponsored activities, or while being transported in a district vehicle.

ASTHMA / ALLERGY

Authorization & Release

A separate written Authorization and Release must be submitted each school year for each prescription medication to be carried and self-administered by a student, and for each change in the dosage, time(s) and/or route of administration.

****This form is NOT to be completed for medical marijuana use.**

[Parent Completes]

Student Name: _____ Student ID#: _____

Date of Birth: _____ Grade: _____ School Year: _____

School Student Attends _____

[Health Care Provider Completes]

Health Care Provider Authorization and Directions

Name of Prescription Medication: _____ Purpose of Medicine: _____

Dosage: _____ Frequency of Use: _____

Length of Time between Doses: _____ Route of Administration: _____

Starting Date: _____ Ending Date: _____

(All Authorizations expire July 31st of the current year)

Possible Side Effects of Medication: _____

_____

By signing below, I affirm that this student has been instructed and is capable of self-administering the prescribed medication and that this student has demonstrated to me, or my designee, the skill level necessary to use the medication and any device used to administer the medication as prescribed. Further, I affirm that in collaboration with the student's school nurse, a written treatment plan has been developed.

Printed Name of Health Care Provider: _____ Office Phone: _____

Signature of Provider: _____ Date: _____

[Parent/Guardian, Student, and School Nurse Reads]

Terms and Conditions

Parent/Guardian: 1) agrees to ensure that his/her child carries the prescribed medication named in the Health Care Provider Authorization and Directions and any device used to administer such medication as prescribed; 2) understands and agrees to provide a back-up of the prescribed medication and any device necessary to administer such medication, to be maintained by the health office for emergencies; 3) agrees to notify the school of any changes to his/her child's treatment plan.

Student: 1) will personally carry the prescribed medication named in the Health Care Provider Authorization and Directions and any device used to administer such medication as prescribed; 2) will use the prescribed medication and any device used to administer such medication in a responsible manner, according to the health care providers orders and the treatment plan; 3) will not allow any other person to use the prescribed medication and/or any device used to administer such medication; 4) will notify the school health office if the prescribed medication is not relieving the symptoms of the condition; 5) will notify the school health office immediately if his/her EpiPen has been used.

School Nurse: 1) will ensure that the student has demonstrated the skill level necessary to use the prescribed medication and any device used to administer the medication as prescribed; 2) will notify school staff that have a need to know about the student's condition and the need to carry the prescribed medication and any device used to administer such medication; 3) will determine, to the best of his/her knowledge, that the student is capable of self-administering the prescribed medication in accordance with the health care action plan; 4) upon notification that the student has used his/her EpiPen, will take action to provide for appropriate follow-up care, which shall include promptly making a 911 emergency call.

[Parent Completes]

Student Name: _____ Student ID#: _____

Date of Birth: _____ Grade: _____ School Year: _____

School Student Attends: _____

Name of Prescription Medication: _____

[Parent Completes]

Parent/Guardian Request, Permission and Release

I hereby request and give my permission for Poudre School District R-1 to allow to my child to carry and self-administer the prescribed medication named in the Health Care Provider Authorization and Directions on page 1 of this form, as specified by the health care provider. In connection with my request, I hereby authorize the health care provider to provide information to the School Nurse regarding the prescription medicine and its use by the student. If my request is granted (as noted by the school nurse's signature in the PSD Authorization below), I hereby release and hold harmless the School District 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 or disregard of the criteria of the treatment plan) 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 prescribed medication as provided above.

By signing below, I affirm that I understand and agree to the Terms and Conditions on page 1 of this Authorization and Release. Furthermore, I affirm that the prescription medication will be carried in the original pharmacy labeled container. My child's name, name of the medication, dosage, name of prescribing health care provider (who is required to furnish Health Care Provider Authorization and Directions above), date prescription was filled, and expiration date will be printed on the medication container's pharmacy label. If this is an over-the-counter medication prescribed for my child's condition, it will be carried in the original container labeled by the pharmaceutical company or other commercial distributor of the medication.

Signature of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

[Student Reads and Signs]

Student Acknowledgement

By signing below, I affirm that I understand and agree to the Terms and Conditions on page 1 of this Authorization and Release. Furthermore, I acknowledge that carrying and self-administering prescription medication to treat asthma, severe allergies or other life-threatening conditions at school, at a school-sponsored activity, or while being transported in a District vehicle is a privilege that may be lost if not exercised responsibly and safely, as determined by the school nurse and building principal and that the authorization for me to carry and self-administer such prescription medication may be revoked at any time if I fail to comply with the Terms and Conditions of this Authorization and Release and/or rules set forth in district policy JLCD (Administering Medicines to Students) including but not limited to the responsibility to immediately report the use of an EpiPen at a school, at a school-sponsored activity, or while being transported in a District vehicle to the school nurse, an employee in the school office, or another school official.

Signature of Student: _____ Date: _____

[School Nurse Signs]

PSD Authorization

By signing below, I affirm that I understand and agree to the Terms and Conditions on page 1 of this Authorization and Release. Furthermore, I affirm that this student has demonstrated to me the skill level necessary to use the medication and any device used to administer the medication as prescribed. Further, I affirm that in collaboration with the student's health care provider, a written treatment plan has been developed for managing the student's asthma or anaphylaxis episodes and for the student's medication use, which treatment plan is on file in the school health office.

School Nurse Signature: _____ Date: _____