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

Permission for Medication Administration
Outdoor Education
(One form per each medication)

The parent/guardian of _____asks that properly trained and delegated school staff give
(Child's name)
the following Medication _____to my child according to the Health Provider's signed
(Name of medication)
instructions on the lower part of this form.

The School agrees to administer medication prescribed by a health care provider licensed in the state of Colorado.
It is the Parent/guardian's responsibility to furnish the medication and to complete and submit the requested information.

The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped as well as the licensed health care provider's name. Pharmacy name and phone number must be packaged in original container. For Outdoor Education 3 doses of extra med may be provided.

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

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 and/or school staff delegated to administer medications.

_____ _____ _____
PRINT - Parent/Legal Guardian's Name SIGNATURE - Parent/Legal Guardian Date

_____ _____ _____
Parent Work Phone Parent Home Phone School Name & Fax Number

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Health Care Provider Authorization to Administer Medication
(To be filled out & signed by health care provider WITH PRESCRIPTIVE AUTHORITY)

Child's Name_____**Birthdate:**_____

Medication: _____

Dosage:_____**Route:**_____ T**ime(s):**_____

Special Instructions:_____**Self Carry:**_____

Purpose of Medication: _____

Side Effects that need to be reported: _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority **License Number**

_____ _____
Printed **name of Health Care Provider** **Date**

_____ _____
Health Clinic Phone Number **Doctor Health Clinic FAX Number**

Please ask the pharmacist for separate labeled medicine to remain at school. THANK YOU!!