Medication Agreement

Annual *Authorization from a Parent/ Legal Guardian and Healthcare Provider is Required for* ***All*** *Medication*

As Parent/Guardian of _____ _____/_____/_____

Student Name *Birthdate*

I give permission to the school staff of Jefferson County Public Schools to administer the medication for my child as ordered or directed by a Healthcare provider (practitioner with prescriptive authority in the state of Colorado). **All** medications are administered by a district registered nurse or school personnel who has been trained and delegated by the district RN for medication administration. I also understand and agree to the following conditions:

1. In compliance with Jeffco Public School District Policy JLCD, Administering Medications to Students, it calls for **All** medications that are administered at school or during a school sponsored event be signed by a Healthcare provider and a parent/legal guardian.**All** medication includes prescription, over the counter, herbal/homeopathic, and (non) essential oils.
2. **All** medication must be supplied in the original pharmacy container label stating student's name, name of medication, dosage, route and number of doses per day, times of administration, and date of discontinuance, if relevant.
3. Medication must not be expired.
4. Over the counter and herbal/homeopathic medications including (non) essential oils must also be supplied in the original package and manufacturer's dosage must be age appropriate. *If the Healthcare provider is recommending a dosage that is different than manufacturer's instructions, then the Healthcare provider must provide an additional comment explaining the recommendations.*
5. It is understood that the medication is being given at the request of the parent/legal guardian as an accommodation to the parent/legal guardian. The parent/legal guardian agrees to release Jefferson County School District and staff from any and all claims which they now have or may thereafter have arising out of the administration of medication to the student that is consistent with the prescription label and/or direction label on the over the counter and herbal/homeopathic, or (non)essential oils medication package.
6. Per BOE policy JLC and Colorado Nursing Board Policy #30-04, district RN have the obligation to verify orders if needed by calling physicians directly.

By signing, the parent/legal guardian agrees that Jefferson County District RN may contact the outside healthcare provider for further information regarding the student's medical condition and needs. It is also agreed that the outside Healthcare provider is granted permission to release confidential information to Jeffco Public Schools district RN Staff. It is understood that all information is kept confidential and used for the sole purpose of developing a medical accommodation plan in order to meet the educational needs of the student.

Please Note For medications that need to be given at home and school, please ask pharmacist for separate, accurately labeled medication bottle to be kept at school. **Be Advised** It is the parent/legal guardian responsibility to pick up student medication by student dismissal the last day of school.

_____ _____

Signature of the Parent/Legal Guardian *Month, Day, Year*

Healthcare Provider Signed Order for Medication *This form must be completed for* ***all*** *medication, including over-the-counters, herbals, homeopathics, and (non)essential oils that a student will need to take during school or school sponsored event.*

Student's Name:_____ Grade: _____ Date of Birth _____/_____/_____

Medication Name (one med per form):_____ Dosage: _____

Route:_____ Frequency:_____ Times to be given at school: _____

Starting Date _____/_____/_____ Ending Date: _____/_____/_____ or until the end of the school year including summer school.

Purpose of Medication: _____ Allergies: _____

Additional comments from the healthcare provider: _____

_____ _____ _____

Print Name of Healthcare Provider prescribing medication Phone Fax

_____ _____ _____

Signature of Healthcare Provider with prescriptive authority Date Clinic Name

_____ _____ _____

Print name of District RN **Signature** of District RN Date

District RN signature indicates that the medication and medication orders have been reviewed by District RN.