



INSTRUCTIONS/AUTHORIZATION FOR ADMINISTERING MEDICATION TO STUDENTS (JLCD-E)

Student Name: _____ School: _____

Student Address: _____ DOB: _____

Parent(s), Legal Guardian(s), or Custodian(s): _____

Telephone: _____ Emergency Telephone: _____

By signing below, I request that Pueblo School District 60 nurses, nursing staff, and designated school personnel administer medication to my student as described and directed below. I give consent to the Pueblo School District 60 nurses, nursing staff, and designated school personnel to review my student's education records, including but not limited to attendance and other school records to assist the staff in helping administer medication(s) to my student. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. Nursing staff may disclose information regarding treatment of my student to third parties as they may determine to be necessary in accordance with acceptable medical practice and applicable law. If my student is self-administering medication (only applies to inhalers, epinephrine, diabetes supplies or other life-threatening conditions), I/we release and hold harmless Pueblo School District 60, its elected officials, the school, employees, and representatives ("Released Parties") from any and all liability for any claims, loss, damage, injury, or expense that my student may suffer as a result of, but not limited to, my student self-administering the medication. I hereby expressly agree to waive any and all claims, whether known or unknown, now existing or arising at any time in the future, that I have or on my student's behalf against the Released Parties arising from the administration of medication to my student in accordance with the instructions provided.

Parent, Legal Guardian, or Custodian Signature

Date

FOR HEALTHCARE PRACTITIONER USE ONLY

Name of Medication: _____ Dosage/Amount: _____

Time/Route Medication is to be administered: _____

(PRN medications must include exact dosage, frequency, & specific purpose)

Purpose of Medication: _____

Possible Side Effects of Medication: _____

Handling Instructions for Medication: _____

(Should the medication be refrigerated, etc.?)

Start Date for Medication: _____

Termination Date for Medication (automatically expires at end of current school year): _____

- ☐ **Self-Carrying inhalers, epinephrine, or other life-saving medication(s):** Check this box if it is medically necessary for the child to carry this medication on their person at all times, and the student has been instructed and demonstrates the skill level necessary to self-administer the prescribed medication(s). This applies only to inhalers for asthma, epinephrine for severe and life-threatening allergies, diabetes supplies or other life-threatening conditions. Final approval will be made by the School Nurse, in accordance with policy JLCD/JLCD-R.

Licensed Prescribing Practitioner Name: _____

Name of Clinic: _____

Address: _____ Telephone: _____

Licensed Prescribing Practitioner Signature

Date

Reviewed by Pueblo School District 60 School Nurse:

School Nurse Signature

Date