El Paso County School District #22- Ellicott (High School)

PHYSICIAN'S AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

- Students taking required medication(s) prescribed by a physician during regular school days or other school activity that is supervised by school staff may be assisted by the school nurse or other designated school staff who are trained/supervised by the school nurse.
- Medications are administered to students only if the school district receives specific written instruction from such physician and the parent or guardian of the student.
- Physician, please give specific parameters to administer medication. Designated school staff cannot make medical judgment to administer "as needed" medication.

Student_____Grade____Classroom_____

Medication is given for what diagnosis/condition?_____

Medication_____Dosage_____

Route: oral topical inhaled other_____Time of day/frequency to be given_____
(circle which)

Anticipated length of time to be given at school_____

Purpose of medication_____

Possible side effects_____

Provider, please complete for emergency medication only (for severe asthma, anaphylaxis, or other life-threatening condition):

The student may carry the emergency medication identified above. ___Yes ___No

I have instructed the student in the proper use and administration of the medication. ___Yes ___No

He/she is capable of self-administration ___Yes ___No

Physician
signature/Stamp_____Date_____

PARENT REQUEST THAT SCHOOL ADMINISTER MEDICATION

I request that medication be administered to my child by the school nurse or other designated member of the school staff in accordance with the instructions on the Physician's authorization. Please give my child their medication at_____
(what time, with food, before PE, special instructions, etc)

I understand that it is my responsibility to furnish this medication in a pharmacy labeled container indicating: child's name, name of drug, dosage, and instructions for administration.

I will notify the school immediately if the medication is to be changed or terminated or if we change physicians.

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by the Ellicott School District, the undersigned parent or guardian hereby agrees to release the Ellicott School District and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication

I hereby give my permission for _____
(name of student)
to take the above named prescription at school as ordered.

Parent, in order for your child to carry their emergency medication at school, you must complete a Contract for Student Carrying/Self Administering Medication, have the above Physician Authorization completed and signed, and return your request to the school nurse for review.

Parent Signature_____Date_____

My child is enrolled in: Medicaid___ CHP+___ Insurance___ No insurance___

I would like information about CHP+/Medicaid: Yes___ No___

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Adopted: 11-15-07