Student Medication 2020/2021

Parents are encouraged to administer medication to their children outside of school hours if possible. Only medications that are required to enable a student to stay in school may be given at school. If necessary, medication prescriptions or over the counters can be given at school under the following conditions:

1. All medications must be ordered by providers with prescriptive authority in Colorado (MD, DO, NP, PA).
2. All medication forms must be renewed each school year (1 full year) and signed by parents and provider in all cases.
3. Medications must be in the **original, properly labeled container**. **Medications sent in baggies or unlabeled containers will not be given.**
4. All medications must be kept in the health room. Self-carry medications need to be evaluated by the school nurse.
5. **Emergency asthma or allergy medication** may be carried and self-administered by a responsible student as determined by the school nurse. A written contract is required between student, parent, physician and school nurse.
6. **If medication is an Inhaler, Insulin, Anti-convulsant or EPI-pen, student needs an Emergency Care plan with Medication Orders signed by provider. We have Asthma, Allergy, Diabetic, and Seizure Emergency Care Plans available. The above emergency care plans also have medication orders thus you will not need this form.**

✓**The information/form below must be completed and signed by the health care provider.**

✓**In addition, the medication bottle must match the prescription as written below.**

STUDENT NAME: _____
First Last

SCHOOL: THE VANGUARD SCHOOL GRADE: _____ DOB: _____

MEDICATION: _____ DOSAGE: _____

TIME TO BE GIVEN: _____ ROUTE: _____

✓**If PRN, (as needed) please note the minimum duration time between doses** i.e. PRN every 4 hours as needed.

Time frame: **This form expires: (1) at the end of the District 12 Calendar School Year:_____ or**

(2) specific time frame: from _____ to _____.

Date:_____ Signature: _____Phone Number:_____
Physician/NP/PA Physician/NP/PA

Health Care Provider's Printed Name _____

PARENT / GUARDIAN: To be completed by the student's parent or guardian

REQUEST AND AUTHORIZATION TO ADMINISTER MEDICATION: I, _____ the parent or guardian of _____, request and authorize that the medication identified above be administered to my student by school personnel as prescribed by her/his physician in the manners specified above. I understand that it is my responsibility to furnish the medication to the school in a properly labeled container. I give permission for my child's health care provider to share information about the administration of this medication with the school nurse or delegated medication staff.

RELEASE FROM LIABIITY: Further, I , for myself and my heirs, hereby fully release and discharge the School District, and The Vanguard School, from any and all claims, obligations, actions, liabilities, or damages of any kind, related to medication side effects, whether known or unknown, now or hereafter arising, which are related in any way to the administration of the medication provided by me.

Date:_____ Signature:_____

Please contact the school nurse for information on this contract or additional forms or care plans.

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