Elizabeth SCHOOL DISTRICT

PERMISSION TO GIVE PRESCRIPTION/HOMEOPATHIC MEDICATIONS AT SCHOOL

The school nurse is required by Colorado State Law to have this form signed by a parent/guardian and the student's healthcare provider before any prescription or homeopathic medication may be given at school.

For safety reasons, parents/guardians are requested to bring the medication directly to the health office. If medication cannot be delivered to the health office by the parent/guardian, please contact the health office to make other arrangements. Prescription meds must be in the original pharmacy labeled container that includes the student's name, medication name, dosage, administration directions & provider's name. New forms must be completed with any changes in medication, dose or time to be given. Parent/guardian agrees to pick up expired or unused medication within 1 week of notification or it will be destroyed.

TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER WITH PRESCRIPTIVE AUTHORITY:

Student Name: _____ Date of Birth: _____

Medication: _____ Dosage: _____

Route: _____ To be given at the following time(s): _____

Purpose of medication: _____

Special Instructions: _____

Side effects that need to be reported (including adverse reactions: _____

_____

Starting Date: _____ Ending Date: _____

_____ _____

Signature of Health Care Provider with Prescriptive Authority License Number

_____ _____ _____

Print Name of Health Care Provider w/Prescriptive Authority Phone Fax

ATTENTION PRESCRIBERS: If this RX is for a rescue inhaler or epi pen:

☐ This student has been instructed by the healthcare provider in the proper use of this medication and the student is capable of carrying and self-administering this medication. _____

Signature of Health Care Provider

By signing this document, I give permission for the nurse or nurse designee to administer this medication as prescribed. Should the nurse have any concerns about this order, I give my permission for this Health Care Provider to share information about this medication's administration with the Registered Nurse

_____ _____ _____

Parent/Guardian Signature Phone Date

THIS FORM MUST BE RESUBMITTED AT THE BEGINNING OF EVERY SCHOOL YEAR.