

ORDER & CONSENT FOR MEDICATION TO BE ADMINISTERED AT SCHOOL



Dedicated to Excellence
Cherry Creek Schools

All medications to be administered at school require an "Order & Consent for Medication" form to be signed by the student's prescribing healthcare provider with prescriptive authority and parent/guardian. These medications include both over the counter and prescription medications.

TO BE COMPLETED BY THE PRESCRIBING PROVIDER WITH PRESCRIPTIVE AUTHORITY

Student's Name: _____ Date of Birth: _____

Medication Name: _____

Dosage: _____

Route: _____ Time(s): _____

Special Instructions: _____

Purpose of Medication: _____

Side effects/ adverse reactions to be aware of: _____

SIGNATURE OF HEALTHCARE PROVIDER & PRINTED NAME

DATE SIGNED – ORDER EXPIRES IN 12 MONTHS

LICENSE NUMBER

PROVIDER PHONE & FAX NUMBER

ATTENTION PROVIDERS: IF THIS IS FOR A RESCUE INHALER or EPINEPHRINE please complete the Colorado Asthma Care Plan and Medication Order for School and Child Care Settings and/or the Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders.

School District Policy JLCA requires, as a condition to its agreement to administer any medication to students, that the medicine be prescribed by a healthcare provider with prescriptive authority and furnished by the parent(s)/guardian(s) of the student with the original pharmacy container label adhered stating the; student's name, name of medication, dosage, time for and how often it is to be administered, name of licensed healthcare provider with prescriptive authority, current date printed on the label and the date when the medication is to be discontinued.

For safety reasons, it is requested that parents/guardians bring the medication directly to the school health clinic staff.

The parent/guardian must pick up expired/unused medication prior to the last day of school or the medication will be disposed of per Colorado Board of Health Guidelines.

It is understood that the medication is given at the request of the undersigned parent/guardian. By signing this document, I (parent/guardian of the above identified student), give permission for the school nurse or identified school staff designee to administer the medication as prescribed by the provider listed above and give my permission for the healthcare provider to share information about this medication's administration with the school nurse or identified school staff designee.

PARENT/GUARDIAN SIGNATURE & PRINTED NAME

PARENT/GUARDIAN PHONE

DATE SIGNED
Permission expires in 12 months.

An updated form must be submitted annually or with any changes to the medication administration.