Cherry Creek School District #5 School: _____

Fax #: _____

PERMISSION TO GIVE PRESCRIPTION/HOMEOPATHIC MEDICATION AT SCHOOL

The school nurse is required by Colorado State Law to have this form signed by the parents and the Health Care Provider of a student before prescription medication can be administered at school. For safety reasons, parents are requested to bring the medication directly to the nurse. If medication cannot be delivered to the clinic by the parent/guardian, please contact the health clinic to make other arrangements. Prescription meds must be in a pharmacy-labeled container that includes the child's name, medication, dosage, the prescriber's name and directions for administration. Some homeopathic preparations may require a review from the Cherry Creek School District Medical Advisory Board. New forms must be completed with any changes in medication, dose or time to be given. The parent agrees to pick up expired or unused medication within one week of notification or it will be destroyed.

To be completed by Licensed Health Care Provider with prescriptive authority:

Student's Name: _____ Date of Birth: _____

Medication: _____

Dosage: _____ Route: _____

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

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____,

including any adverse reaction.

Starting Date: _____ Ending Date: _____

_____ _____

(Signature of Health Care Provider with Prescriptive Authority) (License Number)

_____ _____ _____

(Print name of Health Care Provider with 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 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 the 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 consent must be resubmitted at the beginning of every school year.

RV 04-10

CLINIC FAX: 720.747.3185