Big Sandy School District 100J
18091 CR 125, POB 68
Simla, CO 80835
Ph: 719.541.2291 Fx: 719.541.2443

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.
- No student is denied access to medication prescribed for treatment of urgent or emergent condition.
- Medications are administered to students only if the school receives specific written instruction from such physician and the parent or guardian of the student.

Student____DOB____________Grade____Classroom__________

Physician/Medical Provider section:

Medication is given for what diagnosis/condition?____

Medication____Dosage______________________

Route: ☐ oral ☐ topical ☐ inhaled ☐ other____

Time of day/frequency to be given ____
(Provider, please give specific parameters to administer; do not state "as needed"; ie, noon, prior to PE, peak flow of____, etc. Designated school staff cannot make medical judgment to administer "as needed" medication.)

Anticipated length of time to be given at school____

Purpose of medication____

Possible side effects____

Big Sandy School allows students in 6th grade and above to carry and self-administer non-injectable emergency medication if appropriate.

In accordance with SB 05-156, Colorado School Children's Asthma and Anaphylaxis Health Management Act, please check box and indicate:
•I (physician/medical provider) have instructed this child in the correct and responsible use of the above named medication. ☐ Yes ☐ No
•This child ☐ MAY ☐ MAY NOT carry and self-administer the above named medication.

Physician signature/Stamp____**Date**__________

Parent section: 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/Medical Provider'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 Big Sandy SD, the undersigned parent or guardian hereby agrees to release the Big Sandy SD 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 my child to take the above named prescription at school as prescribed.

Parent/Guardian Signature____**Date**__________

Parent/Guardian, if you want your child to carry/self administer his/her medication, please complete back of form……………

Parent/Guardian request that child (6th grade and above only) carry and self-administer their emergency medication:

Initial each in first column and sign below: Your child will initial second column after review with the nurse.

_____ _____ I have instructed my child in appropriate and safe self-administration of their asthma medication.

_____ _____ I have instructed my child that he/she is NOT to share medication with another student under any circumstances.

_____ _____ I have instructed my child in responsible and safe storage of their medication while at school.

_____ _____ I have instructed my child to notify an adult when they have self-administered their medication.

_____ _____ I have instructed my child to notify an adult when medication has not relieved symptoms and/or if asthma symptoms are worsening.

_____ _____ I understand that irresponsible and/or inappropriate behavior of my child regarding their medication will require school to reassess the privilege of self-carry and self-medicate and that school staff may revoke the privilege as necessary or for the duration of the school year.

Parent/Guardian Signature____ **Date**____________

Emergency contact(s): name, relationship, phone

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Dear Parent/Guardian,

If your child must have medication of any type, including over-the-counter medicine, given during school hours, you may:

1. Come to the school and give it to your child at the appropriate time.
2. Discuss with your doctor an alternative schedule of medication so that it can be given outside of school hours.
3. Provide a note from the doctor-indicating drug, dose, time to be given at school, with your doctor's signature or stamp or use the school form (properly completed).
   - You must provide the medication in a properly labeled pharmacy container that would include: name, drug, dose, instructions for administration.
   - (over-the-counter example: Tylenol in a new unopened bottle with all labels intact, accompanied by doctor's and your written instruction *and the medication dose on the form matches the dose on the bottle provided.*)

In fairness to those giving the medications and in safety for your child, these policies must be followed strictly. We ask this not to make things difficult for you, but to insure the health and well-being of all students.

Remember, the only way we can give medication at school is with properly completed documentation from you and your doctor and a properly labeled container of medication.

School Nurse to complete:

School Staff: In addition to school day...
This plan is effective for school sponsored activity. You must ensure that this student has their medication available for field trips/athletics, etc. If you have questions or concerns regarding this plan, please contact school nurse.

Trained/Delegated STAFF MEMBERS

1.____________________ Date________ 2.____________________ Date________

3.____________________ Date________ 4.____________________ Date________

Comments:____

____

☐ This plan has been reviewed with student ☐ This student may carry/self-administer their medication

Student Signature____ Date____________

School Nurse Signature____ Date____________

Medication located:	Expiration dates: Inhaler