EAGLE COUNTY SCHOOLS

Request for Medication Administration at _____Fax No. _____

Required by Colorado law for All *Prescription or Over-the-Counter* Medications

The parent/guardian of (student's name)_____ request that the school nurse or medication trained staff give the medication listed below according to the Health Care Provider's signed instructions below.

Per the Colorado Nurse Practice Act, the parent/guardian must:

1. Furnish medicine to the Health Office. Then, pick up expired or unused medication within one week or medication will be disposed. General medications are sent home the last week of school unless it is a controlled substance or an Epi-pen.

2. Prescription and/or Over the counter medication must come *with a doctor's order, parent permission, plus be in the original, non-expired, container. Pharmacy-labeled container* must have the name of the student, the medicine, time to be given, dosage amount, the date medicine is to be stopped, and the licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

3. Sharing of information: By signing this, I give permission for the school health staff to communicate with the health care provider(s), pharmacy, or other appropriate person/clinic re: this student's medical condition or medication (by phone, fax, email, or scan) on issues re: dosing, student's refusal to take meds, side effects, reports of suicidal thoughts, etc. It is understood that the medication is administered solely at the request of & as an accommodation to the undersigned parent or guardian. *Note*: A Health Care Plan may be required to be on file.

4. Release of liability: In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by PCS & it's district, the undersigned parent or guardian hereby agrees to release PCS, its district, 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 above student to take the prescription medication as ordered.

_____
Parent/Legal Guardian's Printed Name

Grade:_____ Teacher: _____ Ext: ____ RM:_____

_____
Parent/Legal Guardian's Signature

Home & Cell Phone: _____

Email: _____ Work Phone: _____

Health Care Provider Authorization to Administer Medication at School *(to be filled out by prescribing provider)*

Student: _____ Birth date: _____

Medication (*one per form*):_____ Dose: _____ Route:_____

To be given at the following time(s):_____ Allergies: Insects Food Unknown Other?: _____

Condition/Purpose of medication: _____ Special Instructions: _____

Reportable Side effects: _____ Other: _____

May Student self-carry? Yes No May Student 'self-administer'? Yes No

Starting Date: _____Ending Date: _____ or ☐ until end of school year

Other medications student is on: _____

Print HCP Name: _____License Number: _____ Office Phone: _____

Signature of HCP w/ Prescriptive Authority_____ Office FAX: _____

Please ask the pharmacist for a separate medicine bottle to keep at school. Thank you!

EAGLE COUNTY SCHOOLS

Permiso para administrar medicamentos en la escuela _____Fax No.

Requerido por la Ley de Colorado para todas las *medicinas con o sin receta médica*

Los padres de familia del niño(a) _____ (nombre del alumno) dan permiso a la enfermera escolar o a la persona encargada para administrar el medicamento mencionado, según las órdenes que indique el médico (abajo).

De acuerdo con el Decreto de Enfermería de Colorado, los padres de familia deben:

1. **Llevar el medicamento a la enfermería. Recoger el medicamento si no se ha usado o ha caducado.** Si no se recoge en una semana, se desechará. Los medicamentos generales se envían a casa la última semana de clases, a no ser que sea una sustancia controlada, como Epi-pen.
2. **Las medicinas con o sin receta médica** deben venir con una nota del doctor, con la hoja de permiso formada por los padres de familia y en el envase original, que no haya caducado. La etiqueta del envase debe tener el nombre del estudiante, el tipo de medicamento, hora de administración, dosis, hasta qué día se debe de administrar, el nombre del médico, el nombre de la farmacia y el número telefónico.
3. **Divulgación de información:** Al firmar este documento yo doy permiso para que el personal de enfermería se comunique (por teléfono, fax, correo electrónico o escaneo) con el médico, la farmacia o consultorio clínico con respecto al medicamento, salud de mi hijo, dosis, si el niño no quiere tomar la medicina, efectos secundarios, pensamientos suicidas, etc. Se entiende que el medicamento será administrado a petición o como favor para el padre de familia, abajo firmante. Nota: Se podría requerir un plan de salud en los registros.
4. **Liberación de responsabilidad:** Tomando en cuenta que la enfermera o encargado escolar se encarga de administrar el medicamento, por medio de la presente, el padre de familia abajo firmante no demandará a PCS, al distrito o al personal por denuncias actuales o futuras que puedan surgir de los efectos secundarios o consecuencias médicas del medicamento.

Por medio de la presente, doy permiso para que mi hijo(a) tome la medicina, tal y como dice la receta.

_____
Nombre del padre de familia

Grado: _____ Maestra: _____

_____
Firma del padre de familia

 # Telefónico del hogar y celular: _____

Email: _____ # telefónico del trabajo: _____

El médico o consultorio deben llenar esta parte

Health Care Provider Authorization to Administer Medication at School

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Condition/Purpose of medication: _____ Special Instructions: _____

Reportable Side effects: _____ Other: _____

May Student self-carry? Yes No May Student 'self-administer'? Yes No

Starting Date: _____ Ending Date: _____ or ☐ until end of school year

Other medications student is on: _____

Printed HCP Name: _____ License Number: _____ Office Phone: _____

Signature /HCP Prescriptive Authority:_____Office FAX: _____

***Please ask the pharmacist for a separate medicine bottle to keep at school. Thank you!*