DENVER PUBLIC SCHOOLS | Nursing and Student Health Services

STUDENT MEDICATION ADMINISTRATION AGREEMENT

The undersigned parent(s) or guardian(s) of:

Name of Student _____**Date of Birth** ____/____/____ hereby request school staff(s) employed by the Denver Public School District to administer to said child the medication or treatment as described by the prescribing medical provider's signed instructions below.

In compliance with School District Medication Policy and Procedure and Medication Administration CDE guidance, which requires as a condition of its agreement to administer any medication, that the medicine has been prescribed by a medical provider with prescriptive authority and that it has been furnished by the parent/guardian(s) of the student with the original pharmacy container label stating the child's name, name of the medication, the dosage, the route, the number of doses per day or time(s) and the date when the medication is to be discontinued (if applicable). This applies to all medications including over-the-counter and homeopathic medications including essential oils. It is understood that the medication is given solely at the request of and as an accommodation to the undersigned parent/guardian(s). The undersigned parent/guardian(s) hereby agree(s) to release the Denver Public Schools and its school staff from any and all claim(s) which they now have or may hereafter have to arise out of the administration of, or failure to administer, the medication to the student.
By signing, the parent/guardian agrees that Denver Public Schools Staff, including the Nursing & Student Health Services Director and/or designee, and the school nurse at the student's school, may contact outside providers for further information about the student's medical needs. It is also agreed that the outside provider is granted permission to release confidential information to DPS staff. It is understood that this information will be kept confidential, and will be used only for the purpose of making a decision about the relevance of the Medical Accommodation Plan to the educational needs of the student.

*__PLEASE NOTE:__ For medication to be given at home and school, please ask the pharmacist for a separate, accurately labeled medication bottle to be kept at school.
*__BE ADVISED:__ It is the Parents'/Guardians' responsibility to pick up student medication by student dismissal on the last day of school. Medications left unclaimed will be disposed of according to the Colorado Department of Public Health and Environment (CDPHE) Medical and Pharmaceutical Waste Guidance.

_____ _____

Signature of Parent or Guardian Month/Day/Year

MEDICAL PROVIDER SIGNED ORDER FOR MEDICATION

This form must be completed for any medication a student will need to take during school day and school related activities.
*Please be aware that any medications, including samples, **must** have a medication label to be administered at school.*

Student's Name: _____ Grade: _____ Date of Birth: _____/_____/____

Medication/Treatment Name (*one per form*) _____ Dosage: _____

Route: _____ Frequency: _____ Times given at School: _____

Starting date: ____/____/____ Ending date: ____/____/____ or until end of school year

Purpose of Medication: _____ Allergies: _____

Possible Side Effects: _____

_____ Phone: _____ Fax: _____
(Print) Name of prescribing medical provider

_____ Date: ____/____/____ Clinic Name: _____
Signature of prescribing medical provider

_____ / _____Date:___/___/___
(Print) Name of School Nurse **Signature of School Nurse**
***School Nurse Signature indicates that the medication and medication orders have been reviewed by school nurse**