MANITOU SPRINGS SCHOOLS, DISTRICT 14

PHYSICIAN'S AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Students required to take medication(s) prescribed by a physician during regular school days may be assisted by the school nurse or other designated school personnel. Medications, prescription and over-the-counter, are administered only if the school district receives specific written instruction from such physician and the parents or guardian of the student.

AUTHORIZATION TO ASSIST IN ADMINISTRATION OF MEDICATION

The medication requested below may be administered by the designated school personnel.

Student: _____ Grade: _____

Medication is given for (diagnosis/condition)?: _____

Medication: _____ Dosage: _____

Route (oral/shot, etc.): _____ Time of day to be given at school: _____

Anticipated length of time to be given at school: _____

Purpose of medication: _____

Possible side effects: _____

DOCTOR: For Asthma inhalers only: This student MAY / MAY NOT carry their own inhaler.

Physician Signature/Stamp: _____ Date: _____

PARENT REQUEST THAT SCHOOL ADMINISTER MEDICATION

I request that this medication be administered to my child by the designated member of the school staff in accordance with the instructions on the Physician's authorization. Please give my child their medication at _____ (time of day, with/without food, before PE, other special instructions). 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, discontinued, and/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 School District, the undersigned parent or guardian hereby agrees to release the School 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 my student: _____ to take the above named prescription at school as ordered.

Parent Signature: _____ Date: _____

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MEDICATION POLICY

Dear Parents/Guardians,

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

1) Come to school and administer 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 completed **Physician's Authorization for the Administration of Medication by School Personnel** form (available in the school office, on the other side of this form, and on the MSSD14 website under the Heath tab). This must be completed and signed by the physician and parent.

Any *prescription medication* must be in a labeled pharmacy container that includes: student's name, name of medication, dose, and instructions for administration.

Any *over-the-counter medication* must be in its' original and unopened container.

Each medication requires a separate written authorization. If your student uses an inhaler and/or an Epi-Pen and carries it with them while in the MS or HS, a **Contract to Carry form** must be signed by the student, parent, and school nurse.

This is a school district policy and it is for the safety of your student and the staff administering the medication. This policy must be strictly followed and is the only way that we will be able to administer medication to your child.

Thank you for your assistance.

LeAnn Sharon, MBA, BSN, RN
MSSD 14 School Nurse
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