Arapahoe Charter School

Authorization of Medication

Physician Complete

Student Name_____ Date of Birth _____

In order to keep this student in optimum health and to help maintain school performance, it is necessary that medication be given during school hours.

Medication: _____ Dosage:_____ Route:_____

Time(s) medication is to be given :_____

To be given from (date) _____ to _____

For PRN medications please describe the specific circumstances in which the medication should be administered _____

Significant Information : include side effects, toxic reactions, omission reactions: _____

_____

Contraindications of Administration:_____

Student ☐ may NOT self-carry and self-administer medication

Student ☐ may self-carry and self-administer medication. **Adult supervision is not needed**. The student has been instructed in the treatment plan, self-administration for the listed medication and has demonstrated the skill level necessary to self-administer the medication.

Physician Signature _____ Date_____

Telephone_____

_____

Parent/Guardian Complete

I understand that:

-Non-medical personnel may conduct the medication administration.

-It is my responsibility to have an adult transport the medication to school in the original container labeled with my childs name.

-If medication is not available at the school, 911 will be called for emergencies.

I request that:

-My child be administered the medication as indicated above.

-If an emergency injection is ordered, I give permission for the school nurse to instruct designated staff in the administration technique.

I authorize:

-The release and exchange of medical information between my child's physician and Arapahoe Charter School that is necessary in carrying out services for my child.

I hereby give my permission for my child to receive medication during school hours. The medication has been prescribed by a licensed physician. **I hereby release** Arapahoe Charter School, their agents, board members, and employees from any and all liability that may result from my child taking the prescribed medication.

Parent/Guardian Signature_____ Date_____

Phone_____