Adams 12 Five Star Schools

PARENT/LEGAL GUARDIAN'S RELEASE FOR ADMINISTRATION OF MEDICATION AT SCHOOL
AND
PHYSICIAN'S SIGNED ORDER

The undersigned **parent/legal guardian** of _____ hereby requests
(Student's name)
Personnel employed by Adams 12 Five Star Schools to administer or supervise administration of medication as ordered below by prescribing physician. ***This is effective for the current school year.***

It is required by Adams 12 Five Star Schools, as a condition to its agreement to administer any medication, that the medication be prescribed by a licensed physician, dentist or other authorized prescriber and that it will be furnished by the parent/guardian of the student in a container dispensed by a pharmacy or original over-the counter container which is labeled with the student's name, medication name, dosage, and time when the medication is to be given. It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. By signing this release I hereby authorize employed personnel of Adams 12 Five Star Schools to contact the physician, if necessary, to clarify any written order. Adams 12 Five Star Schools policy requires that medications (both prescription and over-the-counter) be kept in a locked area of the school health office. The medication will be administered by Adams 12 Five Star Schools personnel according to the physician's written order/treatment plan, parent permission and as specified in Superintendent's Policy 5141.

_____

PRINTED NAME of Physician/Dentist /Authorized Prescriber **SCHOOL** **PHONE** **FAX**

PARENT Signature: _____ **DATE:** _____

PHYSICIAN'S SIGNED ORDER FOR MEDICATION ADMINISTERED AT SCHOOL

MEDICATION NAME _____

MEDICATION DOSAGE

1. TABLETS/CAPSULES/LIQUIDS/AMPULES _____ **MG**
OR
2. INHALERS _____ **NUMBER OF PUFFS**

ROUTE
☐ **ORAL** ☐ **TOPICAL** ☐ **RECTAL** ☐ **INHALED** ☐ **NEBULIZER**

SYMPTOMS _____

FREQUENCY _____

☐ **PRIOR TO EXERCISE**
☐ **MAY BE REPEATED EVERY** _____

START DATE _____

STOP DATE _____

PURPOSE _____

_____

POSSIBLE SIDE EFFECTS _____

_____

OTHER COMMENTS _____

_____

_____

FOR EMERGENCY MEDICATIONS (EPI-PENS AND/OR RESCUE INHALERS) THAT WILL BE CARRIED BY THE STUDENT COMPLETE THE REVERSE SIDE. MUST BE RENEWED EACH SCHOOL YEAR.

Physician/Dentist/Other Authorized Prescriber Signature _____ Date _____

Office Address _____ City _____ Zip Code _____

Office Phone Number _____ Office Fax Number _____

Adams 12 Five Star Schools

PHYSICIAN ORDER / HEALTH PLAN FOR STUDENT TO CARRY EMERGENCY MEDICATION AT SCHOOL

STUDENT NAME _____ **MEDICATION NAME** _____

As specified in Superintendent's Policy 5141, there are a few specific and significant situations when a health care provider will write directions for a student to keep emergency medication with them at all times, even during the school day. ***Considerations for self-carry should include the student's age and capability to self-administer emergency medication as well as the student's ability to comply with the District's policy on carrying emergency medication.***

SAFETY AND PROTECTION IS PARAMOUNT FOR ALL STUDENTS AT SCHOOL AT ALL TIMES – THEREFORE THERE ARE CERTAIN RESPONSIBILITIES THAT THE FAMILY AND STUDENT MUST ASSUME WHEN THE STUDENT WILL CARRY EMERGENCY MEDICATION DURING THE SCHOOL DAY.
By signing, below, I/we agree to comply with the terms of this plan and the provisions of Superintendent Policy 5141. Parent/guardian releases Adams 12 Five Star Schools, its employees, agents, and volunteers from any and all liability related to the student's self-administration of ordered medication(s) except that parent/guardian does not waive any claim related to the willful or wanton misconduct by the District or its employees, agents, and volunteers.

CONTRACT FOR STUDENT TO CARRY AND SELF-ADMINISTER EMERGENCY MEDICATION

- ☐ Healthcare provider confirms that the student has been instructed in and is capable of self-carry ***and*** self-administration of the ordered emergency medication.
- ☐ Physician has completed the medication order on the reverse side.

PHYSICIAN Signature: _____ **DATE**: _____

- ☐ I plan to keep my rescue inhaler and/or Epi-Pen with me while at school rather than in the school health office. It may not be left unattended in any classroom, student desk, or backpack (exception may be made for locked PE lockers for rescue inhaler)
- ☐ I agree to use my rescue inhaler and/or Epi-Pen in a responsible manner, in accordance with my physician's order.
- ☐ I agree to notify the school health aide or other appropriate staff if I am having difficulty with my asthma not relieved by using my rescue inhaler.
- ☐ I agree to notify the school health aide or other appropriate staff if I use my Epi-Pen or am experiencing symptoms of a severe allergic reaction so that 911 can be called immediately.
- ☐ I agree to ***NOT ALLOW*** any other person (adult or student) to use my emergency medication.

STUDENT Signature: _____ **DATE:** _____

- ☐ I agree to ensure that my child carries his/her emergency medication as prescribed, and that the medication is in the properly pharmacy labeled container and is not expired.
- ☐ I agree / decline to keep recommended back-up emergency medication in the school health office.
- ☐ I agree to review the status of my child's health with the District Registered Nurse on a regular basis and as needed to implement this treatment plan.

PARENT Signature: _____ **DATE:** _____

- ☐ The above named student has demonstrated the correct technique for inhaler and/or Epi-Pen use.
- ☐ The above named student verbalized an understanding of following the physician's order for time and dosage for the prescribed medication(s).
- ☐ Appropriate district personnel have been notified about the student's medical condition and need to carry emergency medication while at school.

DISTRICT REGISTERED NURSE Signature: _____ **DATE:** _____