Student Medication Request and Release Agreement

Student: _____ DOB: _____ School Year _____

Name of Medication	Reason for Medication	Medication Dosage in MG	Route	Time(s) Medication to be Given
☐ Albuterol ☐ Xopenex ☐ _____	Asthma *Symptoms-(list): 1. 2. 3. 4. 5.	☐ 2 Puffs ☐ Other: _____	☐ Inhaled ☐ With Spacer	☐ Every 4 hours as needed for *symptoms ☐ May repeat in _____minutes ☐ Prior to exercise
☐ Epinephrine Auto Injector* ****If Colorado State Anaphylaxis Health Care Plan is signed & completed by physician this form does not have to be completed***	Life threatening Allergies-(list): 1. 2. 3. 4. 5.	☐ 0.15 mg ☐ 0.3 mg	Intra-muscular (IM)	☐ Upon Exposure ☐ Severe Reaction: Short of breath, wheeze, cough, pale, faint, dizzy, confused, tight throat, hoarse ☐ Repeat if no improvement in 10 minutes
☐ Diphenhydramine (Benadryl) ☐ Other Antihistamine		☐ 12.5 mg ☐ 18.75 mg ☐ 25 mg ☐ 37.5 mg ☐ 50 mg ☐ Other: _____mg	By Mouth (PO)	☐ Upon Exposure ☐ For MILD reaction: Itchy mouth, a few hives around mouth/face, mild itching, mild nausea/discomfort
		_____ mg		
		_____ mg		

Physician's Signature: _____ Date: _____

Prescribing Physician Name: _____ Physician's Phone: _____

Parent/Guardian Signature: _____ Date: _____

School District Policy JLCD requires, as a condition to its agreement to release any medication, that the medicine be prescribed by a physician or dentist and furnished by the parent(s) of the student with the original pharmacy container label stating the student's name, name of the medication, the dosage, the number of dosages per day or time(s) when the medication is to be released to the student, and the date when the medication is to be stopped (if applicable). It is understood that the medication is given solely at the request of, and as an accommodation to, the undersigned parent(s) or guardian(s). The undersigned parent(s) or guardian(s) hereby agree(s) to release the Douglas County School District RE-1 and its personnel from any and all claim(s), which they now have or may hereafter have arising out of the release of the medication to the student.

☐ Reviewed/complete ☐ Needs clarification

School Nurse Signature: _____ Date: _____