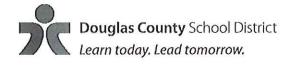
## Student Medication Request and Release Agreement

Student:			DOB:	School Year
Name of Medication	Reason for Medication	Medication Dosage in MG	Route	Time(s) Medication to be Given
☐ Albuterol	Asthma *Symptoms-(list):	☐ 2 Puffs	☐ Inhaled	Every 4 hours as needed for *symptoms
☐ Xopenex	1. 2.	Other:	☐ With Spacer	☐ May repeat inminutes
	3. 4. 5.			☐ 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	By Mouth (PO)	☐ Upon Exposure ☐ For MILD reaction: Itchy mouth, a few hives around mouth/face, mild itching, mild
Other Antinistamine		☐ 50 mg ☐ Other:mg		nausea/discomfort
		mg		
		mg		
Physician's Signature:				Date:
				ician's Phone:
				Date:
School District Policy JLCD requires, as parent(s) of the student with the origina when the medication is to be released to request of and as an accommodation to	s a condition to its agreement to I pharmacy container label stati the student, and the date when to the undersigned parent(s) or	release any medication, that ng the student's name, name the medication is to be stopp- guardian(s). The undersigne	the medicine be prescre of the medication, the ed (if applicable). It is u	ibed by a physician or dentist and furnished by the dosage, the number of dosages per day or time(s) nderstood that the medication is given solely at the (s) hereby agree(s) to release the Douglas County e release of the medication to the student.
☐ Reviewed/complete	☐ Needs clarification	n		
School Nurse Signature:				Date:

## PERMISSION TO CARRY/SELF-ADMINISTER MEDICATION

STUDENT	NAME	DATE		
SCHOOL _		DOB		
MEDICATIO	ON	DOSAGE		
Route of Ac	lministration	Time/Frequency		
Purpose of	Medication			
student ("Si correct self- and timing, responsible been instru	tudent"), I have determined that the Stud -administration of the above-listed medica /frequency of use of the Medication. The and able to properly carry and self-adm	ent's parent(s)/guardian(s), as well as my own assessment of the lent is able to identify his/her correct medication, demonstrate ation ("Medication"), and has knowledge of the required dosage Student has knowledge of his/her condition and is sufficiently hinister the Medication during the school day. The Student has and frequency of use of the Medication and is capable of self-impleted for all medication changes.		
(Physician Signature)		(Date)		
(Physician's Printed Name)		(Physician's Telephone Number)		
undersigned Douglas Co	d parent(s) or guardian(s). The undersi-	nistered solely at the request of, and as an accommodation to, the gned parent(s) or guardian(s) hereby agree(s) to release the nnel from any and all claim(s), which they now have or may f the Student's use of the Medication.		
(Parent or Guardian Signature)		(Date)		
For studer conditions		tis, severe allergies, and/or other related life-threatening		
	The School Nurse and the above-referent nanagement plan, which is attached to this	nced Physician have collaborated to formulate a health care form.		
	The School Nurse, the above-referenced Carry/Self Administer Medication Contract	Physician and the Student have entered into a Permission to which is attached to this form.		
Correspond	ing District policy JLCD is located at: http:	//www1dcsdk12/ResourceLibrary/JLCD.pdf		
Adopted: Revised: Cross Ref.: Legal Refs.:	ed: April 4, 2006, to conform to current law; December 8, 2005; May 16, 2006 Ref.: JLCD			
Douglas Co	anty School District Re. 1, Castle Rock, Colo	prado		



## CONTRACT TO CARRY/SELF-ADMINISTER MEDICATION

This Contract is for students diagnosed with asthma, anaphylaxis, severe allergies, and/or other related life-threatening conditions and is in effect for the current school year unless revoked by a physician or if the Student fails to meet contingencies cited below.

Student Name		Date		
School		DOB		
Medication	i	Purpose of Medication		
Student:	I agree to keep my Medication with me at school and use referenced health care provider.  I will notify school office staff if my condition for which difficulty.  I will notify the office staff if and when I use the Medication I will not allow any other student to administer my Medica be disciplined in accordance with the Douglas County Schodo, I will be appropriately disciplined in accordance with Conduct and Discipline.  I understand that if I fail to comply with this contract, my may be withdrawn.	I am prescribed the Medication presents any unusua tion to him or herself and understand that if I do, I wil ol District Re.1's Student Code and understand that if Douglas County School District Re.1's Student Code o		
(Student Sig	gnature)	(Date of Signature)		
Parent or 6	I will assure that my child, the above-referenced Student, we device containing the Medication and provided to the all pharmacist or healthcare provider and contains Medication I will assure that back-up Medication is provided to the emergencies.  I will review the attached health care plan on a regular basing some contains.	bove-referenced school is appropriately labeled by a that has not expired.  health office staff at the above-referenced school for		
(Parent/Gu	ardian Signature)	(Date of Signature)		
School Nur	I will assure that the Student can demonstrate the correct to I will assure that the Student has an understanding of the attime and dosages for self-administering the Medication. I agree to assure that appropriate school staff is made at Student to carry the Medication.  I agree to review on a regular basis with the Student, the above.  I agree to assign a designee to make a 911 emergency call it require his/her use of epinephrine (Epi-pen).*	bove-references physician's order pertaining to proper ware of the Student's condition and the need for the e status of the Student's asthma/allergy as identified		
(School Nu	rse Signature)	(Date of Signature)		
* Only appli	es to students who are prescribed epinephrine.			

