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:** _____

PERMISSION TO CARRY/SELF-ADMINISTER MEDICATION

STUDENT NAME _____ **DATE** _____

SCHOOL _____ **DOB** _____

MEDICATION _____ **DOSAGE** _____

Route of Administration _____ **Time/Frequency** _____

Purpose of Medication _____

Through my consultation with the above-named student's parent(s)/guardian(s), as well as my own assessment of the student ("Student"), I have determined that the Student is able to identify his/her correct medication, demonstrate correct self-administration of the above-listed medication ("Medication"), and has knowledge of the required dosage and timing/frequency of use of the Medication. The Student has knowledge of his/her condition and is sufficiently responsible and able to properly carry and self-administer the Medication during the school day. The Student has been instructed in the purpose, appropriate method, and frequency of use of the Medication and is capable of self-administering the Medication. A new form must be completed for all medication changes.

_____ _____

(Physician Signature) (Date)

_____ _____

(Physician's Printed Name) (Physician's Telephone Number)

It is understood that the Medication will be self-administered 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 relating to an act or omission of the Student's use of the Medication.

_____ _____

(Parent or Guardian Signature) (Date)

For students diagnosed with asthma, anaphylaxis, severe allergies, and/or other related life-threatening conditions:

- ☐ The School Nurse and the above-referenced Physician have collaborated to formulate a health care management plan, which is attached to this form.
- ☐ The School Nurse, the above-referenced Physician and the Student have entered into a Permission to Carry/Self Administer Medication Contract which is attached to this form.

Corresponding District policy JLCD is located at: http://www1dcsdk12/ResourceLibrary/JLCD.pdf

Adopted: October 1, 1991
Revised: April 4, 2006, to conform to current law; December 8, 2005; May 16, 2006
Cross Ref.: JLCD
Legal Refs.: C.R.S. 22-1-119

Douglas County School District Re. 1, Castle Rock, Colorado

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 _____ **Purpose of Medication** _____

Student:

- I agree to keep my Medication with me at school and use it in a responsible manner as instructed by my above referenced health care provider.
- I will notify school office staff if my condition for which I am prescribed the Medication presents any unusual difficulty.
- I will notify the office staff if and when I use the Medication.
- I will not allow any other student to administer my Medication to him or herself and understand that if I do, I will be disciplined in accordance with the Douglas County School District Re.1's Student Code and understand that if I do, I will be appropriately disciplined in accordance with Douglas County School District Re.1's Student Code of Conduct and Discipline.
- I understand that if I fail to comply with this contract, my privilege to carry and self-administer the Medication may be withdrawn.

_____ _____

(Student Signature) (Date of Signature)

Parent or Guardian:

- I will assure that my child, the above-referenced Student, will carry his/her Medication as prescribed, and that the device containing the Medication and provided to the above-referenced school is appropriately labeled by a pharmacist or healthcare provider and contains Medication that has not expired.
- I will assure that back-up Medication is provided to the health office staff at the above-referenced school for emergencies.
- I will review the attached health care plan on a regular basis with my child.

_____ _____

(Parent/Guardian Signature) (Date of Signature)

School Nurse:

- I will assure that the Student can demonstrate the correct technique for self-administering the Medication.
- I will assure that the Student has an understanding of the above-references physician's order pertaining to proper time and dosages for self-administering the Medication.
- I agree to assure that appropriate school staff is made aware of the Student's condition and the need for the Student to carry the Medication.
- I agree to review on a regular basis with the Student, the status of the Student's asthma/allergy as identified above.
- I agree to assign a designee to make a 911 emergency call if and when the Student is exposed in such a way as to require his/her use of epinephrine (Epi-pen).*

_____ _____

(School Nurse Signature) (Date of Signature)

* Only applies to students who are prescribed epinephrine.