Weld County RE-5J School District
Administering Medicine to Student at School or School-Sponsored Activity

****A separate written Authorization and Release must be submitted <u>each school year</u> for each medicine to be administered to a student, and for each change in the dosage, time(s) and/or route of administration.**

Student Name_____
Date of Birth: _____ Grade:_____ School Year: _____
School Student Attends:_____Fax Number: _____
School/Activity where Medicine is to be Administered:_____

Health Care Provider Authorization and Directions:

Name of Medicine:_____

The Medicine is: ❒ Prescription ❒ Nonprescription

May this student carry and use emergency medications (Epipen, inhaler, diabetes) independently? Yes_____ No_____ **No other medications may be self carried.**

Purpose of Medicine:_____

Dosage:_____ Route of Administration:_____

Time(s) the Medicine is to be Administered:_____

Starting Date: _____ Ending Date:_____

(All Authorizations expire at the end of the school year)

Possible Side Effects of Medication:_____

Name of Health Care Provider:_____Phone:_____

***Signature of Provider:_____Date:_____**

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Special Instructions

Prescription Medication: Must be furnished in the original pharmacy labeled container. The student's name, name of the medicine, dosage, name of prescribing health care provider (who is required to furnish Health Care Provider Authorization and Directions above), date prescription was filled, and expiration date must be printed on the medicine container's pharmacy label.

Nonprescription Medication: Must be furnished in the original sealed container labeled by the pharmaceutical company or other commercial distributor of the medicine.

Parent/Guardian Request, Permission and Release

I hereby request and give my permission for Weld RE-5J to administer to my child the medicine named in the Health Care Provider Authorization and Directions section above. I understand that it is my responsibility to provide the medication in the original pharmacy-labeled or pharmaceutical container that has the correct medication dosage identified for my student. I also understand the school may not alter or change any medications from their original form (e.g., cut or half pills, etc.). Additionally, in connection with my request, I hereby authorize the health care provider identified above to verify and consult with School District personnel regarding the information provided on this form. Finally, I hereby agree to release and hold harmless the School District, its board members, employees, and agents from any and all claims (except claims for willful and wanton acts or omissions)arising out of the administration of medicine to my child as provided in the Health Care Provider Authorization and Directions section above.

****Signature of Parent/Guardian:_____ Date:_____***

****Nurse Signature: _____ Date: _____***