

Pikes Peak Regional Policy on Student Medication/Care Plan
Within Policy Guidelines of School District 49

Parents are encouraged to administer medication to their children outside of school hours if at all possible. Only medications which are required to enable a student to stay in school may be given at school. If necessary, medications (prescription and over the counter) can be given at school under the following conditions:

1. All medications must be ordered by healthcare providers with prescriptive authority in CO (MD's, DO's, NP's, PA's).
2. All medication forms must be renewed **each school year**.
3. Written permission by parent and physician is required in all cases.
4. Medications must be in the original, properly labeled container. Medications sent in baggies or unlabeled containers will not be given.
5. All medications must be kept in the health room, except for students whose doctor requires them to carry medications on their person (for example, epipen, inhaler, etc).
6. See School Board Policy JLCD and JLCD – R for more information.

The information below must be completed and signed by the physician.

STUDENT NAME: _____
First Name Last Name
DIAGNOSIS: _____ GRADE: _____ DOB: _____
MEDICATION: _____ DOSAGE: _____
TIME TO BE GIVEN: _____ ROUTE: _____
POSSIBLE SIDE EFFECTS: _____

Anticipated time frame: (Must be renewed each school year)
School Year: 2019-2020 OR Specific Time Frame: FROM: _____ TO: _____

If PRN (as needed), please note the minimum duration time between doses (for inhalers: minimum time frequency, frequency between sets of inhalation): _____

Is a second dose of epinephrine allowed if there is an allergic reaction? YES _____ NO _____

If medication is an inhaler or epinephrine, is the student given permission to carry on his/her person?
YES: _____ NO: _____ Physician/NP/PA MUST SIGN BELOW
Parent Signature: _____ Date: _____ Student Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____

Date: _____ Printed Name Physician/NP/PA: _____ Physician/NP/PA Phone Number: _____
Signature
Physician/NA/PA: _____
Date: _____ School Nurse Signature: _____

I hereby give permission for my student to take the above prescription(s) at school as ordered by the physician. I understand that it is my responsibility to furnish this medication(s). I also understand that all medications must be transported to and from school by a parent/guardian or approved emergency contact person.

Date: _____ Parent/Guardian Signature: _____