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).

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: 2016-2017 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 ______

Parent Signature: ___________________________ Date: ____________

Physician/NP/PA MUST SIGN BELOW

Physician/NP/PA: ___________________________ Phone Number: ___________________________

Signature: ___________________________

Date: ____________

Student Signature: ___________________________ Date: ____________

School Nurse Signature: ___________________________ Date: ____________

Printed Name: ___________________________

Physician/NP/PA: ___________________________

Signature: ___________________________

Date: ____________

School Nurse Signature: ___________________________

Parent/Guardian 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: ___________________________

Revised 7/17/2017 jg