MANITOU SPRINGS SCHOOLS, DISTRICT 14
PHYSICIAN'S AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Students required to take medication(s) prescribed by a physician during regular school days may be assisted by the school nurse or other designated school personnel. Medications are administered only if the school district receives specific written instruction from such physician and the parents or guardian of the student.

AUTHORIZATION TO ASSIST IN ADMINISTRATION OF MEDICATION
The medication being requested below may be administered by the designated school personnel.

Student____Grade________________________

Medication is given for what diagnosis/condition?______________________________________

Medication____Dosage__________________

Route____________________Time of day to be given at school___________________________

Anticipated length of time to be given at school__________________________________

Purpose of medication____

Possible side effects____

Doctor, for asthma inhalers only: This student **may** or **may not** carry their own inhaler.

Physician
signature/Stamp____Date______________

PARENT REQUEST THAT SCHOOL ADMINISTER MEDICATION

I request that medication be administered to my child by the designated member of the school staff in accordance with the instructions on the Physician's authorization. Please give my child their medication at____
(what time, with food, before PE, special instructions, etc)

I understand that it is my responsibility to furnish this medication in a pharmacy labeled container indicating: child's name, name of drug, dosage, and instructions for administration.

I will notify the school immediately if the medication is to be changed or terminated or if we change physicians.

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by the School District, the undersigned parent or guardian hereby agrees to release the School District and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication

I hereby give my permission for ____
(name of student)
to take the above named prescription at school as ordered.

Date______________Parent Signature____

My child is enrolled in: Medicaid___ CHP+___ Insurance___ No insurance___

I would like information about CHP+/Medicaid: Yes___ No___