Request for Medication Administration at *Pinnacle Charter School*, Fax-720 274 2056

Required by Colorado law for All *Prescription or Over-the-Counter* Medications

The parent/guardian of (student's name)_____ request that the school nurse or medication trained staff give the medication listed below according to the Health Care Provider's signed instructions below.

Per the Colorado Nurse Practice Act, the parent/guardian must:

1. Provide the medicine to the Health Office. As needed, pick-up expired or unused medication within one week or medication will be disposed. General medications are sent home the last week of school unless it is a controlled substance or an Epi-pen.

2. Prescription and/or Over the counter medication must come *with a doctor's order, parent permission, plus be in the original, non-expired, container. Pharmacy-labeled container* must have the name of the student, the medicine, time to be given, dosage amount, the date medicine is to be stopped, and the licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

3. Sharing of information: By signing this, I give permission for the school health staff to communicate with the health care provider(s), pharmacy, or other appropriate person/clinic re: this student's medical condition or medication (by phone, fax, email, or scan) on issues re: dosing, student's refusal to take meds, side effects, reports of suicidal thoughts, etc. It is understood that the medication is administered solely at the request of & as an accommodation to the undersigned parent or guardian. *Note: A Health Care Plan may be required to be on file.*

4. Release of liability: In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by PCS & it's district, the undersigned parent or guardian hereby agrees to release PCS, its 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 above student to take the prescription medication as ordered.

_____ Yes No Student May Carry Medication Home at End of Year?

Parent/Legal Guardian's Printed Name

Grade:____ Teacher: _____ Ext: ____ RM:____

_____

Parent/Legal Guardian's Signature *Home & Cell Phone:* _____

Email: _____ Work Phone: _____

Health Care Provider Authorization to Administer Medication at School *(to be filled out by prescribing provider)*

Student: _____ **Birth Date:** _____

Medication (*one per form*): _____ **Dose:** _____ **Route:** _____

To be given at the following time(s): _____ **Allergies: Insects Food Unknown Other?:** _____

Condition/Purpose of medication: _____ **Special Instructions:** _____

Reportable Side effects: _____ **Other:** _____

NOTE: *If either Asthma Inhaler or Epi-pen ordered:* May Student carry? Yes No May Student 'self-administer'? Yes No

Starting Date: _____ **Ending Date:** _____ **or ☐ until end of school year**

Other medications student is on: _____

Print HCP Name: _____ **License Number:** _____ **Office Phone:** _____

Signature of HCP w/ Prescriptive Authority _____ **Office FAX:** _____

*****Please ask the pharmacist for a separate medicine bottle to keep at school. Thank you!***