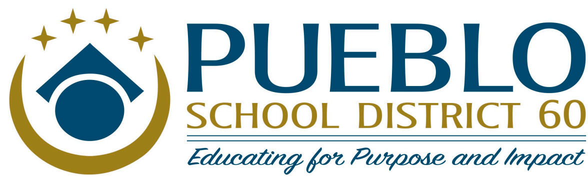

INSTRUCTIONS/CONTRACT FOR ADMINISTERING MEDICATION TO STUDENTS

Student Name:______________________________ School:______________________________

Student Address: ____DOB: ______________

Parent(s), Legal Guardian(s), or Custodian(s: ____

Telephone:____________________________________Emergency Telephone: ______________

* By signing below, I request that Pueblo City Schools nursing and delegated staff administer medication to my child as described and directed below. I give consent to the Pueblo City School's nursing staff to examine my child's education records, including but not limited to attendance and other school records to assist the staff in helping administer medication(s) to my student. Nursing personnel may disclose information regarding treatment of my student to third parties for any reason in accordance with acceptable medical practice and applicable law. If my child is self-administering medication (only applies to inhalers, epinephrine or diabetic supplies), I release and hold harmless Pueblo City Schools, its elected officials, the school, employees and representatives ("Released Parties") from any and all liability for any claims, loss, damage, injury or expense that my child may suffer as a result of, but not limited to, my child self-administering the medication. I hereby expressly agree to waive any and all claims whether known or unknown, now existing or arising at any time in the future, that I have or on my child's behalf against the Released Parties arising from the administration of medication to my child in accordance with the instructions provided.

____

Parent's Signature Date

FOR HEALTHCARE PRACTITIONER USE ONLY

Name of Medication: ______________________________ Dosage/Amount: ______________________________

Time/Route Medication is to be administered: ____

(PRN medications <u>must</u> include exact dosage, frequency & specific purpose)

Purpose of Medication: ____

Special instructions for medication administration: ____

Possible side effects of medication: ____

Handling Instructions for Medication: ____
(*Should the medication be refrigerated, etc.?)*

Start Date for Medication: ____

Termination date for Medication (automatically expires at end of current school year): ______________________

☐ Check this box if it is medically necessary for the child to carry this medication on their person at all times and the student has been instructed and demonstrates the skill level necessary to self-administer the prescribed medications. This applies only to inhalers for asthma, epinephrine auto-injectors for severe and life-threatening allergies, and diabetic supplies with approval from school nurse, in accordance with regulation JLCD/JLCD-R.

Licensed Prescribing Practitioner Name: ____

Name of Clinic: ____

Address: ____ Telephone: ______________

____

Licensed Prescribing Practitioner's Signature Date

<u>Reviewed by District 60 School Nurse</u>:

____

School Nurse Signature Date

Revised 8-15-19