DENVER PUBLIC SCHOOLS
DIVISION OF STUDENT SERVICES
NURSING & STUDENT HEALTH SERVICES
2015/2016

School: _____

Phone: _____

FAX: _____

STUDENT MEDICATION REQUEST RELEASE AGREEMENT

The undersigned parent(s) or guardian(s) of:

Name of Student _____**Date of Birth** ____/____/____ hereby request school staff(s) employed by the Denver Public School District to administer to said child

Name of Medication: _____at (Time given at School) ____ _____
as described by the prescribing Primary Care Provider's (PCP) signed instructions below

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In compliance with School District Policy JLCD- Administering Medicines to Students, which requires as a condition to its agreement to administer any medication, that the medicine has been prescribed by a PCP or dentist and that it has been furnished by the parent/guardian(s) of the student with the original pharmacy container label stating the child's name, name of the medication, the dosage, the route, the number of dosages per day or time(s) and the date when the medication is to be discontinued (if applicable). This applies to all medications including over the counter. It is understood that the medication is given solely at the request of and as an accommodation to the undersigned parent/guardian(s). The undersigned parent/guardian(s) hereby agree(s) to release the Denver Public Schools and its school staffs from any and all claim(s) which they now have or may hereafter have arising out of the administration of, or failure to administer, the medication to the student. At no time will any school staff(s) recommend or require the student be prescribed psychotropic medication(s) to attend school.
By signing, the parent/guardian agrees that Denver Public Schools Staff, including the Manager of Nursing Services or the school nurse at the student's school may contact outside providers for further information about the student's medical needs. It is also agreed that the outside provider is granted permission to release confidential information to DPS staff. It is understood that this information will be kept confidential, and will be used only for the purpose of making a decision about the relevance of the Medical Accommodation Plan to the educational needs of the student.

*__**BE ADVISED:**__ It is the Parents/Guardians responsibility to claim students medication(s) by the last day of the school year. **Medication(s)** left unclaimed will be disposed of according to the Colorado Department of Human Services (CDHS) "Guidelines for Medication Administration (2008)."

_____ _____
Signature of Parent or Guardian Month/Day/Year

PRIMARY CARE PROVIDER (PCP) SIGNED ORDER FOR MEDICATION

This form must be completed for any medication a student will need to take during school hours.
*Please be aware that any medication sample __**must**__ have a medication label to be administered at school.*

Student's Name: _____ Grade: _____ Date of Birth: _____/_____/____

Medication Name (*one per form*) _____ Dosage: _____

Route: _____ Frequency: _____ Times given at School: _____

Starting date: ____/____/____ Ending date: ____/____/____ or until end of school year 2015-2016

Purpose of Medication: _____ Allergies: NKDA Other: _____

Possible Side Effects: _____

_____ Office Phone: _____ _

(Print) Name of PCP or Dentist Prescribing Medication Office Fax: _____

_____ Date: ____/____/____ Clinic Name: _____
Signature of PCP w/Prescriptive Authority

Medication Discontinued: Time: _____ and Date: ____/____/____ PCP Signature: _____

****For medication to be given at home and school, please ask the pharmacist for a separate, accurately labeled medication bottle to be kept at school. Thank You!****

4/15 – for 15/16 School Year