

## MEDICATION ADMINISTRATION AT WINDSOR CHARTER ACADEMY

### PERMISSION FOR MEDICATION

Name of Student: \_\_\_\_\_ Grade: \_\_\_\_ Teacher: \_\_\_\_\_ Date effective: \_\_\_\_\_

Medication: \_\_\_\_\_ Exact Dosage (No Ranges): \_\_\_\_\_

Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time and day medication is to be taken: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

Specific side effects: \_\_\_\_\_

Length of time medication is to be given at school (ex: days, weeks, months, school year): \_\_\_\_\_

Can student carry his/her medication during school hours, at school-sponsored activities and while in transit to/from school-sponsored activities? \_\_\_\_\_ Yes\* \_\_\_\_\_ No

***\*If yes, the health care provider confirms that the student has been instructed in correct and responsible use of the medication and that the student is capable of self-administration. Parents/guardians will assure that the student will carry his/her medication and demonstrate knowledge about the medication and safe use of it. The parent will also accept full responsibility for any misuse of the medication by the student. Student will sign a self-carry contract with the School Nurse.***

Provider's Signature \_\_\_\_\_

Date \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Phone Number: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Note: This completed form and the prescribed medication is to be brought to school in the original bottle or container, with the student's name, name of the medicine, and dosage. This form is good for one medication only. If your child requires multiple medications, please return additional signed and completed forms.

Trained staff members will administer this medication as ordered by the provider during the school day from 7:45am-3:30pm and on field trips. If this medication is necessary for school-sponsored extracurricular activities (clubs, sports, performances, etc.) outside of school hours, the medication will be made available upon request and in accordance with the Non-School Hours Events Protocol outlined in the parent handbook. The School Nurse must be given a reasonable amount of time to train the supervising staff member prior to the activity.

I hereby give permission for my child to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. **I understand that I must notify the School Nurse if this medication will be necessary for extracurricular activities that my child is participating in outside of the school day and that EACH activity will require a separate notification.**

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

**If you have any questions, please contact the School Health Office:**

**Elem. 970-674-5020 Ext. 138**

**MS/HS 970-833-5190 Ext. 211**

**Both Schools FAX: 877-594-4749**

RN Signature \_\_\_\_\_

Date \_\_\_\_\_

## Medication Log

Initials	Name of Person Giving Medication
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Date/Time	Initials	Comments
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[illegible]

**End of Year:**                      **Med Disposal:**

Letter Sent Y N	_____To Parent
Date:	_____Destroyed
Initials:	Date: