District 49 Nursing Services
________________Health Room
________________phone
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Anand
And District 49

Pikes Peak Regional Policy on Student Medication/Care Plan

Within Policy Guidelines of School District 49

Parents are encouraged to administer medication to their children outside of school hours if at all possible. Only medications which are required to enable a student to stay in school may be given at school. If necessary, medications (prescription and over the counter) can be given at school under the following conditions:

1. All medications must be ordered by healthcare providers with prescriptive authority in CO (MD's, DO's, NP's, PA's).
2. All medication forms must be renewed **each school year.**
3. Written permission by parent and physician is required in all cases.
4. Medications must be in the original, properly labeled container. Medications sent in baggies or unlabeled containers will not be given.
5. All medications must be kept in the health room, except for students whose doctor requires them to carry medications on their person (for example, epipen, inhaler, etc).
6. See School Board Policy JLCD and JLCD – R for more information.

The information below must be completed and signed by the physician.

STUDENT NAME: ________________________ ____
First Name Last Name

DIAGNOSIS: ____________________________ GRADE: ________ DOB: __________________

MEDICATION: ___________________________ DOSAGE: _______________________________

TIME TO BE GIVEN: _____________________ ROUTE: ________________________________

POSSIBLE SIDE EFFECTS:____

Anticipated time frame: (Must be renewed each school year)
School Year: ____________ OR Specific Time Frame: FROM: ____________ TO: _____________

If PRN (as needed), please note the minimum duration time between doses (for inhalers: minimum time frequency, frequency between sets of inhalation): _____________________________________

Is a second dose of epinephrine allowed if there is an allergic reaction? YES_____ NO_____

If medication is an inhaler or epinephrine, is the student given permission to carry on his/her person?
YES: ________ NO: _______ **Physician/NP/PA MUST SIGN BELOW**
Parent Signature:_______________Date:___________ Student Signature:___________________ Date:__________
School Nurse Signature:________________________ Date:_______________

Date: _________ **Printed Name Physician/NP/PA:** __________________________ **Physician/NP/PA Phone Number:** __________________

Signature Physician/NA/PA:__________________________

Date: _________ School Nurse Signature: ______________________

I hereby give permission for my student to take the above prescription(s) at school as ordered by the physician. I understand that it is my responsibility to furnish this medication(s). I also understand that all medications must be transported to and from school by a parent/guardian or approved emergency contact person.

Date: _________ **Parent/Guardian Signature**: ____