Kids Are Great Pediatrics

***Robert SayersMD * Janette BachmannMD * Richard Kouri MD * Keith Poston FNP * Kristen Maciel PNP**

320 E. Fontanero, Suite 308
Colorado Springs, CO 80907

719.577.4200 main
719.442.6595 fax

Student Medication Form

School Year: _____ - _____

Student information:

Student Name: _____ School: _____

Date of Birth: ____/____/____ Age: _____ Grade: _____ Teacher: _____

□ No known drug allergies --- if drug allergies Weight: _____ as of ____/____/____

list: _____

Prescriber authorization:

Medication name: _____ Dosage: _____ Route: _____

Frequency/Time(s) to be given: _____ Start date: ___/___/___ End date: ___/___/___ N/A

Reason for taking medication: _____

Potential side effects/contraindications/adverse reaction: _____

_____

Treatment order in the event of an adverse reaction: _____

Special instructions:

Is the medication a controlled substance? Yes No
Is self- medication permitted and recommended? Yes No
If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribed medication.
Do you recommend this medication be kept "on person" by student? Yes No

Printed Name of Licensed Healthcare Provider: _____

Signature of Licensed Healthcare Provider: _____ Date: _____

Parent Authorization:

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened, and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ Date: ___/___/___ Phone: _____

SELF-ADMINISTRATION AUTHORIZATION (To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ Date: ___/___/___ Phone: _____