Stanley British Primary School
350 Quebec Street, Denver, CO 80230
Phone: 303-360-0803 Fax: 303-360-0353 Email: stanleybps.org

Permission for Medication

The parent/guardian of ______________________________________ask that school staff give the following
(Child's name)
medication ____at ____________________________
(Name of medicine and dosage) (Time(s))
to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

PLEASE PROVIDE A SEPARATE PERMISSION FOR MEDICATION FORM FOR EACH MEDICATION.
Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label. **Over the counter medication** must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication. I further acknowledge that this medication is being given at my expressed request and therefore release Stanley British Primary School, its representatives, and employees from any liability or loss related to the administration of this medicine. I understand that I will be notified to pick up medications if the medication is expired, the school year ends, or my child withdraws. All student specific medication(s) that are left at the school will be discarded according to the Colorado Board of Pharmacy recommendations.

______________________________ _________________________________ _____________
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

Health Care Provider Authorization

Child's Name:____ **Birthdate:** ____________________

Medication: ____ **Route** _______________________

Dosage: ________________________________**To be given in school at the following time(s):** _____________________
(Specify exact dosage and amount (i.e. tsp, pills), no ranges please)

If the medication is prn (as needed), please describe symptoms to administer the medication and intervals between dose
____

Special Instructions: ____

Purpose of medication: ____

Side effects that need to be reported: ____

Self Carry Medication for Emergency EpiPen and/or Inhaler
May Self Carry Medication _________ Health Care Provider Initials__________

Starting Date: _______________________ **Ending Date:** ____________________________

____ ______________________________________
Signature of Health Care Provider with Prescriptive Authority **License Number**
____ _________________/____________________
Print Name of Health Care Provider **Phone** **Fax Number**

FOR SCHOOL USE ONLY: MEDICATION VERIFICATION CHECK LIST

Initials		Initials		Initials	
	Parent Signature		*Med Exp Date:*		*Email / Phone/ fax Nurse*
	Health Provider Signature		*Completed Log*		*Notify Staff*
	Checked 5 Rights				
	Count and verify meds				