Student Office
420 South Rush Road • Rush, CO 80833
Phone: (719) 478-2186 • Fax: (719) 478-5380
Website: www.miamiyoder.org

MIAMI-YODER
SCHOOL DISTRICT JT-60

As Parent/Guardian of: ____ *Grade:* ____ *Date of Birth:* ____/_____/____

I give permission to the school staff of Miami-Yoder School District JT-60 El Paso County Public Schools to administer the medication for my child as ordered or directed by a Healthcare provider (practitioner with prescriptive authority in the state of Colorado). **All** medications are administered by a district registered nurse or school personnel who has been trained and delegated by the district RN for medication administration. I also understand and agree to the following conditions:

1. In compliance with Miami-Yoder School District JT-60, requirements for Administering Medications to Students, it calls for **All** medications that are administered at school or during a school sponsored event be signed by a Healthcare provider and a parent/legal guardian. **All** medication includes prescription and all over the counter/non-prescription medications.
2. Any change in medication requires a new form/order to be completed. Medication orders apply to current school year only.
3. **All** medication must be supplied in the original pharmacy container label stating student's name, name of medication, dosage, route and number of doses per day, times of administration, and date of discontinuance, if relevant. Medication must not be expired.
4. Medication must be brought to school office by parent/guardian. Students are not allowed to transport medications without proper Self-Carry contract being approved by health care provider and district nurse.
5. Over the counter must also be supplied in the original package and manufacturer's dosage must be age appropriate. *If the Healthcare provider is recommending a dosage that is different than manufacturer's instructions, then the Healthcare provider must provide an additional comment explaining the recommendations.*
6. It is understood that the medication is being given at the request of the parent/legal guardian as an accommodation to the parent/legal guardian. The parent/legal guardian agrees to release Miami-Yoder School District JT-60 and staff from all claims which they now have or may thereafter have arising out of the administration of medication to the student that is consistent with the prescription label and/or direction label on the over the counter medication package.
7. Per Colorado Nursing Board Policy #30-04, district RN has the obligation to verify orders if needed by calling ordering health care provider directly.

By signing, the parent/legal guardian agrees that Miami-Yoder School District JT-60 RN may contact the outside healthcare provider for further information regarding the student's medical condition and needs. It is also agreed that the outside Healthcare provider is granted permission to release confidential information to Miami-Yoder School District JT-60 district RN. It is understood that all information is kept confidential and used for the sole purpose of developing a medical accommodation plan to meet the educational needs of the student.

Please Note For medications that need to be given at home and school, please ask pharmacist for separate, accurately labeled medication bottle to be kept at school. **Be Advised** It is the parent/legal guardian responsibility to pick up student medication by student dismissal the last day of school.

____ ____ ______________

Printed Name of Parent/Legal Guardian ***Signature of Parent/Legal Guardian*** ***Date***

Healthcare Provider Signed Order for Medication

*This form must be completed for **all** medication, including over-the-counter medications that a student will need to take during school or school sponsored event.*

Student's Name: ____ **Date of Birth**: ______/______/______

Medication Name (one medication order per form): ____ **Dosage:** _________________

Route: ______________________ **Frequency:** _____________________ **Times to be given at school:** ____

Starting Date: ______/______/______ **Ending Date:** ______/______/______ or until the end of the school year including summer school.

Purpose of Medication: ____ **Allergies:** ____

Additional comments from the healthcare provider/Possible side effects: ____

____

____ __________________________ ______________________________

Printed Name of Healthcare Provider prescribing medication **Phone** **Fax:**

____ _______________ ____

Signature of Healthcare Provider with prescriptive authority **Date** **Clinic Name**

____ ____ ______________

Print name of District RN **Signature of District RN** **Date**

District RN signature indicates that the medication and medication orders have been reviewed by District RN.