CIVA CHARTER HIGH SCHOOL
4635 Northpark Drive
Colorado Springs, CO 80918
719-633-1306
719-633-1691 (fax)

Colorado Springs School District 11
Pikes Peak Regional Student Medication Form

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, over the counter, homeopathic and herbal) can be given at school under the following conditions:

1. All medications must be ordered by healthcare providers with prescriptive authority.
2. All medication forms must be renewed each **school year.**
3. Written permission by parent and physician 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 doctors require them to carry medications on their person as per school policy (for example, epipen, inhalers, etc).
6. Health care plan must accompany this form as per school policy.

√ The information/form below must be completed and signed by the physician.
√ In addition, the medication bottle must match the prescription as written below.

STUDENT NAME:_____ _____ _____
First Name Last Name Date of Birth

SCHOOL: _____

MEDICATION:_____ DOSAGE:_____

TIME TO BE GIVEN: _____ ROUTE:_____

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

_____

Anticipated time frame: (Must be renewed each school year)
School Year:_____ OR Specific Time Frame: FROM_____ TO_____

If medication is an inhaler, Epi-Pen, etc.---is the student given permission to carry on his/her person?

YES_____ NO_____ Physician's Initials:
(Physician MUST Initial)_____

Date:_____ Physician Signature_____ Physician Phone Number_____

PARENT / LEGAL GUARDIAN: To be completed by the student's parent or legal guardian

REQUEST AND AUTHORIZATION TO ADMINISTER MEDICATION: I, _____ the parent or legal guardian of _____, request and authorize that the medication identified above be administered to my student by school personnel as prescribed by her/his physician in the manners specified above. I understand that it is my responsibility to furnish the medication to the school in a properly labeled container.

RELEASE FROM LIABIITY: Further, I , for myself and my heirs, survivors, agents, child, immediate family and personal representatives, hereby fully release and forever discharge the School District, its directors, officers, employees, agents, representatives, attorneys, and successors and assigns, from any and all demands, claims, obligations, actions, liabilities, or damages of any kind or nature whatsoever, in law or in equity, whether known or unknown, suspected, now or hereafter arising, which related in any way to the administration of the medication provided by me.

Date:_____ _____
(Signature of Parent or Legal Guardian)