PUEBLO CITY SCHOOLS World Class

Office of Social Services

INSTRUCTIONS/CONTRACT
FOR ADMINISTERING MEDICATION TO STUDENTS

Student Name: _____ School: _____

Student Address: _____ DOB: _____

Parent(s), Legal Guardian(s), or Custodian(s): _____

Telephone: _____ Emergency Telephone: _____

* By signing I give consent to the District 60 nursing personnel to examine my child's school records, attendance and other records to assist the staff in helping my student. Nursing personnel may release information regarding treatment to third party entities for any reason in accordance with acceptable medical practice pursuant to the law. If my child is self-administering medication, I release the school, School District 60, and any associated entity from liability, except in cases of gross negligence, willful or wanton conduct.

_____

Parent's Signature Date

FOR HEALTHCARE PRACTITIONER USE ONLY

Name of Medication: _____ Purpose of Medication: _____

Time/Route Medication is to be administered: _____ Dosage: _____

(PRN medications must include exact dosage, frequency & specific purpose)

Special Instructions/possible side effects: _____

Termination date for Medication: _____

☐ Check this box if it is medically necessary for the child to carry this medication on their person at all time and the student has been instructed and demonstrates the skill level necessary to self administer the prescribed medications.

Licensed Prescribing Practitioner Name: _____

Address: _____ Telephone: _____

_____

Licensed Prescribing Practitioner's Signature Date

STUDENTS (For Epi-pen/Inhaler Self Administration Only)

☐ I plan to keep my rescue inhaler/Epi-pen **(circle one)** with me at school rather than in the assigned school location for medications.

☐ I agree to use my rescue inhaler/Epi-pen **(circle one)** in a responsible manner, in accordance with my health care provider's orders.

☐ I will notify the school health office if I am having more difficulty than usual with my asthma or if I am exposed to an allergen that requires the use of an Epi-pen.

☐ I will not allow any other person to use my inhaler/Epi-pen **(circle one)**

_____

Student's Signature Date

PARENT/GUARDIAN (for Epi-Pen/Inhaler Self Administration Only)

This contract is in effect for the current school year unless revoked by the health care provider or the student fails to meet the above safety contingencies.

☐ I agree to see that my student carries his/her medication as prescribed, that the device contains medication, and the date is current.

☐ It has been recommended to me that a back-up rescue inhaler/Epi-pen (circle one) be provided to the school for emergencies.

☐ I will review the status of the child's asthma/allergy (circle one) with the student on a regular basis as agreed in the treatment /health care plan.

Parent's Signature Date

SCHOOL NURSE CONSULTANT (For Epi-pen/Inhaler Use Only)

☐ This student has demonstrated correct technique for inhaler/Epi-Pen **(circle one)** use, and understanding of the health care provider order for time and dosages.

☐ This student, if prescribed an inhaler, understands the concept of pre-treatment with an inhaler prior to exercise.

☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

☐ The student has a treatment/health care plan for the current school year.

Registered Nurse's Signature Date