Prescription Medication Agreement

Annual Authorization from a Parent / Guardian and a Healthcare Provider
Is Required For All Prescription Medication

JEFFCO PUBLIC SCHOOLS
Building Bright Futures

To be completed by parent or guardian

I hereby request and give my permission to the Jefferson County School District to administer this prescription medication to my child. I understand that it is my responsibility to provide the medication in the original pharmacy/or physician labeled container that has the correct medication dosage identified for my student. I also understand the school may not alter or change any medications from their original form (cut or half pills, etc.) Any prescription changes will require an additional signed and completed Prescription Medication Agreement. I release Jefferson County School District staff from all liability for any injury caused by the administration of the medication in compliance with medication label.

Student Name: ______________________ Birth Date: __________

Parent / Guardian Name (s): ______________________ Phone: __________

Name of Medication: ______________ Dosage: __________ Time: __________

Start Date: ________ End Date: ________ Route: ________ Medication Purpose: __________

I understand that the prescribing healthcare provider or designee may disclose to Jefferson County School District staff all protected information for the purpose of review and evaluation in connection with the administration of medication for one year.
I acknowledge this exception to HIPAA but if questioned authorize this disclosure.

______________________________ ______________
Signature of Parent/Guardian Date

Student Name: ______________________ Birth Date: __________

Medication: ______________ Purpose: ______________

Dosage: __________ Time(s) to be given at school: ______________

Start Date: __________ End Date: __________ Route: __________

Name of Healthcare Provider: __________ Office Phone: __________ Fax __________

______________________________ ______________
Signature of Healthcare Provider Date

Only school staff who are trained and delegated by the District Registered Nurse may administer prescription medications. The employee administering the medication must document and initial the time the medication was administered on the Supplemental Medication Administration Log.

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Name / Signature of District Registered Nurse who trained and delegated prior to the administration of the medication.

Initials	Trained & Delegated Staff	Title	Date Delegated