Medication Administration Permission Form 2017

The parent/guardian of _____ ask that Colorado Academy staff give the
(child's name)
medication described below to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Parents/guardians MUST supply any of the medication(s) to Colorado Academy that may be administered to your child.
The expiration date on the medication bottle MUST NOT EXPIRE BEFORE END OF SUMMER PROGRAM.

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 provide/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.

All medication must be picked up by the parent at the conclusion of each school year. All medication(s) that are left at the school will be discarded according to the most current state regulatory recommendations for safe medication disposal,

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. Further, I acknowledge that medication is administered to my child solely at my request and as an accommodation to me and my child. I understand Colorado Academy does not have the medical personnel on staff at all times to assist in the administration of medication and that medication may be administered by the divisional administrative assistant or designee. In consideration of the acceptance of the request to perform this service by personnel employed by Colorado Academy, I hereby agree to release Colorado Academy and its personnel from all liability, claims or demands for any damage, loss or injury to my child arising out of the administration of (or failure to administer) the medication.

_____ _____ _____
Print Parent/Guardian Name Parent/Guardian Signature Date

_____ _____
Work Phone Home Phone

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Health Care Provider Authorization

Child's Name: _____ Birthdate: _____

Medication: _____ Exact Dose _____ Route _____

To be given at the following time(s): _____ Starting Date: _____ Ending Date: _____

Purpose of medication: _____

Special Instructions including side effects to be reported: _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority License Number

_____ _____ _____
Print Name of Health Care Provider Date Phone

FOR SCHOOL USE ONLY: MEDICATION VERIFICATION CHECK LIST

Delegating RN Signature: _____

Delegated Staff Signature : _____

Completed form must be returned before camper can attend *(Mail, fax, or email acceptable)*.
Fax: 303-914-2532. Email: summer.programs@coloradoacademy.org.