



Authorization to Administer Medication in School Form

Student's First Name	Student's Last Name	Birth Date

Prescription Medication

- If any prescription medication is to be administered during school hours, this form must be completed and signed by a Health Care Provider (HCP) and signed by a parent/guardian. Prescription medications can only be given during school hours by the Health Office when an authorization form is on file with the School's RN.
- A student's medication must be kept in the school's Health Office unless a physician specifies self-carry on this form.
- Medication must be provided by the parent/guardian in the original container in which it was purchased. When ordering prescription medication, please ask the pharmacist to provide an additional empty, labeled bottle to be stored at school.

Over the Counter Medication

- If any over-the-counter medication is to be administered by the Health Office during school hours, this form must be completed by the HCP, signed by the parent/guardian, and given to the school's RN.

Name of Medication (Prescription and Over-the-Counter)	
Dosage	
Route/Method	
Times Given <i>If this is PRN, please specify dosage, amount per day, and timing between doses</i>	
Purpose of Medication <i>Please do not say "as needed", specify the reason to give this medication.</i>	
Potential Side Effects	
Student to Self-Carry? (except for controlled substances)	{CIRCLE} YES NO
End Date (if applicable)	
Health Care Provider contact information for questions/concerns related to the medication administration	Name: Email: Phone:

Health Care Provider Signature _____ Date _____

I hereby request and give my permission for Colorado Early Colleges to administer the medicine named in the above Medication Authorization Form to my student, as specified by the health care provider. If my request is granted (as noted by the RN signature in the CEC Authorization above), I hereby release and hold harmless Colorado Early Colleges, its board members, employees, and agents from any liability, claims, causes of action, damages and demands of any kind whatsoever (except willful and wanton acts or omissions) that may be brought by my student or on my student's behalf for any damages, including personal injury to my student, arising out of or in connection with the administering of medicine to my student as provided above.

Parent/Guardian Signature _____ Date _____

Printed Name _____

Office Use Only - Received and Approved

School Nurse Signature _____ Date _____