# The Denver Waldorf School

# Medication Administration Permission for School and Child Care

The parent/guardian of _____, _____ask that the school/child care staff give the
(Child's Name) (Grade)
following medication, _____ at _____, to
(Name of medication and dosage) (Time(s) if as needed, write "as needed")
my child, according to the Health Care Provider's signed instructions on the lower part of this form.

**Prescription 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 provider's name. Pharmacy name and phone number must also be included on the label.

**Over the counter medications** must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in the original container.

The Program agrees to administer medication prescribed by a licensed health care provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff. 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.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian's Signature Date

_____ _____ _____
Work Phone Cell Phone Home Phone

## Health Care Provider Authorization

**Child's Name:**_____ **Birthdate:**_____

**Medication:** _____ **Dosage:**_____ **Route:**_____

**To be given at the following times:**_____ **Special Instructions:** _____

**Purpose of medication:** _____ **Side effects that need to be reported:** _____

**Starting Date:** _____ **Ending Date:**_____

_____ _____

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

_____ _____/_____

**Print Name of Health Care Provider** **Phone/Fax Number**

### Permission to self-carry medication requires final approval by Nurse Consultant

I give my permission for this student to self-carry his/her medication and have instructed him/her in its proper use.

_____ (Signature of Health Care Provider)

I give my permission for my child to self-carry medication at school. I understand that this privilege can be revoked for misuse. _____ (Signature of Parent/Guardian)

Delegating RN signature:_____ Initials: _____

Delegated Staff signature: _____ Initials: _____