Shepherd of the Hills Christian School

7691 S. University Blvd. Centennial, CO 80122 303-798-0711 ShepherdHills-school.org

Medication Administration

The parent/guardian of _________________________ ask that school/child care staff give the following
(Child's name)

medication ________________________________ at ______________________
(Name of medicine and dosage) (Time(s)

To 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 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.

Shepherd of the Hills 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 Name Date

_________________________________ _________________________________
Work Phone Home Phone

* *

Health Care Provider Authorization

Child's Name ____ **Birth date** ______________________

Medication _________________________________ **Dosage** ___________________ **Route** _____________

To be given at the following time(s) ______________________ **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

FOR SCHOOL USE ONLY: MEDICATION VERIFICATION CHECKLIST

DELEGATING RN SIGNATURE:: ____________________________ **INITIALS:** __________________________

DELEGATED STAFF:: ______________________________________ **INITIALS:** __________________________

Initials		*Initials*		*Initials*	
	Parent Signature		*Med Exp Date:*		*Email/Phone/fax Nurse*
	Health Provider Signature		*Completed Log*		*Notify Staff*
	Checked 5 Rights				
	Count and verify meds				

Children's Hospital Colorado School Health Program