

**MANITOU SPRINGS SCHOOLS, DISTRICT 14**  
**HEALTH CARE PROVIDER'S AUTHORIZATION FOR THE ADMINISTRATION OF**  
**MEDICATION**  
**BY SCHOOL PERSONNEL**

Students required to take medication(s) prescribed by a health care provider during regular school days may be assisted by the school nurse or other designated school personnel. Medications, prescription and over-the-counter are administered only if the school district receives specific written instruction from a health care provider and the parents or guardian of the student. **This form must be completed for each school year.**

**AUTHORIZATION TO ASSIST IN ADMINISTRATION OF MEDICATION**

The medication requested below may be administered by designated school personnel.

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Medication is given for (diagnosis/condition)?: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Route (oral/shot, etc.): \_\_\_\_\_ Time of day to be given at school: \_\_\_\_\_

Anticipated length of time to be given at school: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

DOCTOR: For Asthma inhalers only: This student      MAY / MAY NOT      carry their own inhaler.

Health care provider Signature/Stamp: \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT REQUEST THAT SCHOOL ADMINISTER MEDICATION**

I request that this medication be administered to my child by the designated member of the school staff in accordance with the instructions on the Health Care Provider's authorization. Please give my child their medication at \_\_\_\_\_ (time of day, with/without food, before PE, other special instructions). I understand that it is my responsibility to furnish this medication in a pharmacy labeled container indicating: Child's name, name of drug, dosage, and instructions for administration.

I will notify the school IMMEDIATELY if the medication is to be changed, discontinued, and/or if we change health care providers.

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by the School District, the undersigned parent or guardian hereby agrees to release the School District and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication.

I hereby give my permission for my student: \_\_\_\_\_ to take the above named prescription at school as ordered.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MANITOU SPRINGS SCHOOLS, DISTRICT 14  
MEDICATION POLICY**

Dear Parents/Guardians,

If your child must have medication **of any type**, prescription or over-the-counter, given during school hours, you may:

- 1) Come to school and administer it to your child at the appropriate time.
- 2) Discuss with your health care provider an alternative schedule of medication so that it can be given outside of school hours.
- 3) Provide a completed **Health Care Provider's Authorization for the Administration of Medication by School Personnel** form (available in the school office, on the other side of this form, and on the MSSD14 website; go under District Information, then down to Health Information). This must be completed and signed by the Health Care Provider and parent.

**Any prescription medication must be in a labeled pharmacy container that includes: student's name, name of medication, dose, and instructions for administration.**

**Any over-the-counter medication must be in its original and unopened container.**

**Each medication requires a separate written authorization.** If your student uses an inhaler and/or an Epi-Pen and carries it with them while in the MS or HS, a **Contract to Carry form** must be signed by the student, parent, and school nurse.

This is a school district policy and it is for the safety of your student and the staff administering the medication. This policy must be strictly followed and is the only way that we will be able to administer medication to your child.

Thank you for your assistance,  
MSSD 14 Health Team

Please call your student's school if you need to speak to a health team member.