WESTMINSTER PUBLIC SCHOOLS
MEDICATION ADMINISTRATION AT SCHOOL

School: ________________________________ Phone: _____________ Fax: _____________

Dear Parent/ Guardian,

Westminster Public Schools has a medication policy that is in accordance with Colorado school health guidelines. The policy states that both prescription and over the counter medications (non-prescription medications) may be given at school when the following conditions have been met:

1. **A signed parental permission** clearly stating the name of the medication and the time to be given at school has been received by your child's school.
2. Medication must be in the **original container** labeled with the name of the doctor prescribing the medication, the date, the time it is to be given, how the medication is taken and dosage. (Over the counter medication or non-prescription medication must be in the original container or individual "bubble pack" wrapping.)
3. Parent's permission and original container must be accompanied by **a doctor's signed statement** containing instructions matching those on the container.

School staff is not allowed to give any medications unless all requirements have been met.

We request that whenever possible your child receives his/her medication at home. We would appreciate a maximum 30-day supply at school for a child with ongoing medications. If you have any questions, please contact your child's school.

PERMISSION FOR MEDICATION: TO BE COMPLETED BY PARENT

(A separate form must be completed for each medication)

By signing below, I request and give permission to Westminster Public Schools to administer medication to my child. I understand that it is my responsibility to provide any medication alterations (such as pills that need to be cut in half). I understand that this information may be shared with appropriate school personnel as needed. I give permission for staff to contact the physician as needed regarding this medication. Any prescription changes will require an additional signed and completed Permission for Medication form. I also agree to bring this medication to school in the original prescription container clearly labeled with student's name, physician, medication, date, route, time to be given and dosage. Prescription and over the counter medication must be in the original container or individual "bubble pack" wrapping and must have both parent and physician written permission.

Student Name: ____ Birth date: ___________________________

School: _______________________ Grade: _______________ Teacher: ________________ Time to be given: __________

Medication: _________________________________ Dosage: _______________Route (how to be taken): ______________

Parent Name: _________________________________ Home phone: ________________ Work phone: _________________

(Please Print)

Parent Signature: ____Date: __________________________

TO BE COMPLETED BY PHYSICIAN

Patient's Name: ____ Birth date: _______________________________

Medication: ______________________________________ Dosage: __________________________ Route: _____________

Time(s) to be given at school: __________________________ Side effects that may need to be reported: _________________

Daily prescribed medication may be given late with parent verbal authorization to medication certified staff ☐ Yes ☐ No

Middle/High School ONLY: student may carry inhaler & self-administer (please circle one) Yes No ______________

(Physician Please Initial)

Number of days medication needs to be given at school: __________________ *OR* Entire School Year ☐ (Check box if applies)

Physician signature: __________________________________

Physician Name (printed): ______________________________

Date: ___________________________

OFFICE STAMP *(Or Print Health Care Provider Name, Address, Phone and Fax Numbers)*

Completed form may be faxed directly to student's school.

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