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 student and parent contact information.
2. **Please use the Asthma Care Plan for inhalers and the Severe Allergy Care Plan for epinephrine auto-injectors**
3. 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.)
4. Parent's permission and original container must be accompanied by **a doctor's signed statement** containing instructions matching those on the container.
5. Medication must not be expired.

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: _____

Parent Name: _____ Home phone: _____ Work phone: _____
(Please Print)

Parent Signature: _____Date: _____

TO BE COMPLETED BY PHYSICIAN

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 ☐ 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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