DENVER PUBLIC SCHOOLS
DIVISION OF STUDENT SERVICES
NURSING & STUDENT HEALTH SERVICES
2022-2023

School: _____

Phone: _____

FAX: _____

STUDENT MEDICATION/TREATMENT REQUEST RELEASE AGREEMENT

The undersigned parent(s) or guardian(s) of:

Name of Student _____**Date of Birth** ____/____/____ hereby request school staff(s) employed by the Denver Public School District to administer to said child the medication or treatment as described by the prescribing Primary Care Provider's (PCP) signed instructions below.

In compliance with School District Medication Policy and Procedure, which requires as a condition to its agreement to administer any medication, that the medicine has been prescribed by a PCP or dentist and that it has been furnished by the parent/guardian(s) of the student with the original pharmacy container label stating the child's name, name of the medication, the dosage, the route, the number of dosages per day or time(s) and the date when the medication is to be discontinued (if applicable). This applies to all medications including over the counter. It is understood that the medication is given solely at the request of and as an accommodation to the undersigned parent/guardian(s). The undersigned parent/guardian(s) hereby agree(s) to release the Denver Public Schools and its school staffs from any and all claim(s) which they now have or may hereafter have arising out of the administration of, or failure to administer, the medication to the student. At no time will any school staff(s) recommend or require the student be prescribed psychotropic medication(s) to attend school.
By signing, the parent/guardian agrees that Denver Public Schools Staff, including the Nursing Services Manager and/or designee, and the school nurse at the student's school may contact outside providers for further information about the student's medical needs. It is also agreed that the outside provider is granted permission to release confidential information to DPS staff. It is understood that this information will be kept confidential, and will be used only for the purpose of making a decision about the relevance of the Medical Accommodation Plan to the educational needs of the student.

PLEASE NOTE: For medication to be given at home and school, please ask the pharmacist for a separate, accurately labeled medication bottle to be kept at school.
BE ADVISED: It is the Parents/Guardians responsibility to pick up student medication by student dismissal the last day of the school. Medications left unclaimed will be disposed of according to the Colorado Department of Human Services (CDHS) "Guidelines for Medication Administration (2008)."

_____ _____
Signature of Parent or Guardian Month/Day/Year

PRIMARY CARE PROVIDER (PCP) SIGNED ORDER FOR MEDICATION

This form must be completed for any medication a student will need to take during school hours.
*Please be aware that any medications, including samples, **must** have a medication label to be administered at school.*

Student's Name: _____ Grade: _____ Date of Birth: _____/_____/____

Medication/Treatment Name (*one per form*) _____ Dosage: _____

Route: _____ Frequency: _____ Times given at School: _____

Starting date: ____/____/____ Ending date: ____/____/____ or until end of school year 2019-2020
Purpose of Medication: _____ Allergies: NKDA Other: _____

Possible Side Effects: _____
_____ Phone: _____ Fax: _____
(Print) Name of PCP or Dentist Prescribing Medication

_____ Date: ____/____/____ Clinic Name: _____
Signature of PCP w/Prescriptive Authority

Medication Discontinued: Time: _____ and Date: ____/____/____ PCP Signature: _____

_____ / _____Date:___/___/___
(Print) Name of School Nurse Signature of School Nurse

School Nurse Signature indicates that the medication and medication orders have been reviewed by School RN
02/18/2020