



Health Services  
2407 LaPorte Ave  
Fort Collins CO 80521

## Carry and Self-Administer Medicine at School or School-Sponsored Activity

### HIGH SCHOOL STUDENTS Authorization & Release

A separate written Authorization and Release must be submitted each school year for each medicine to be carried and self-administered by a high school student, and for each change in the dosage, time(s) and/or route of administration.

[Parent Completes]

Student Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: \_\_\_\_\_  
 School/Activity where medicine is to be administered: \_\_\_\_\_  
 Name of Medicine \_\_\_\_\_

[Health Care Provider Completes]

#### Health Care Provider Authorization and Directions

Name of Medicine: \_\_\_\_\_  
 The Medicine is:  Prescription  Nonprescription  
 Purpose of Medicine: \_\_\_\_\_  
 Dosage: \_\_\_\_\_ Route of Administration: \_\_\_\_\_  
 Time(s) the Medicine is to be administered: \_\_\_\_\_  
 Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_  
*(All Authorizations expire at the end of the school year)*  
 Possible Side Effects of Medication: \_\_\_\_\_  
 \_\_\_\_\_  
 Printed Name of Health Care Provider: \_\_\_\_\_ Office Phone: \_\_\_\_\_  
 Signature of Provider: \_\_\_\_\_ Date: \_\_\_\_\_

#### Special Instructions

The high school student is only authorized to carry and self-administer a one-day dose of medicine at school or the school-sponsored activity as specified above, except that more than a one-day dose may be authorized by the school nurse and building principal if necessitated by the length of the school-sponsored activity.

The high school student shall at all times maintain the security of his or her medicine so that it may not be taken by or otherwise fall into the possession of another person.

**Prescription Medication:** Must be furnished in the original pharmacy labeled container. The student's name, name of the medicine, dosage, name of prescribing health care provider (who is required to furnish Health Care Provider Authorization and Directions above), date prescription was filled, and expiration date must be printed on the medicine container's pharmacy label.

**Nonprescription Medication:** Must be furnished in the original container labeled by the pharmaceutical company or other commercial distributor of the medicine.

*Continued on next page*

*Carry and Self-Administer Medicine at School or School-Sponsored Activity—HIGH SCHOOL STUDENTS  
Authorization and Release, continued*

[Parent Completes]

Student Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: \_\_\_\_\_  
School/Activity where medicine is to be administered: \_\_\_\_\_  
Name of Medicine \_\_\_\_\_

[Parent Reads and Signs]

**Parent/Guardian Request, Permission and Release**

I hereby request and give my permission for Poudre School District R-1 to allow my child to carry and self-administer the medicine named in the Health Care Provider Authorization and Directions on page 1 of this form, as specified by the health care provider. In connection with my request, I hereby authorize the health provider to provide information to School District personnel who may be involved in determining if my child will be authorized to carry and self-administer the medication and its use by the student.

If my request is granted (as noted by the school nurse and building principal signatures in the PSD Authorization below), I hereby release and hold harmless the School District and its board members, employees and agents from any and all liability, claims, causes of action, damages and demands of any kind whatsoever (except willful and wanton acts or omissions) that may be brought by my child or on my child's behalf for any and all damages, including personal injury to my child, arising out of or in connection with my child carrying and self-administering the medicine as provided above.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

[Student Reads and Signs]

**Student Acknowledgement**

I acknowledge that carrying and self-administering medicine at school or a school-sponsored activity is a privilege that may be lost if not exercised responsibly and safely, as determined by the school nurse and building principal, and that the Authorization for me to carry and self-administer the medicine noted above may be revoked at any time if I fail to comply with the rules set forth in district policy JLCD (Administering Medicines to Students).

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

[PSD Staff Signs]

**PSD Authorization** – by signing below, the school nurse and building principal represent that they have determined this high school student has the ability to properly self-administer the medicine, and that the high school student is sufficiently mature and responsible to safely carry and self-administer the medicine at school or a school-sponsored activity in compliance with applicable District policies and regulations.

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Building Principal Signature: \_\_\_\_\_ Date: \_\_\_\_\_