

**DENVER PUBLIC SCHOOLS**  
**DIVISION OF STUDENT SERVICES**  
**NURSING & STUDENT HEALTH SERVICES**  
**2011/2012**

School: Bromwell Elementary

Phone: 720-424-9340

FAX: 720-424-9355

**STUDENT MEDICATION 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

**Name of Medication:** \_\_\_\_\_ at (Time given at School) \_\_\_\_\_ as described by the prescribing Primary Care Provider's (PCP) signed instructions below

In compliance with School District Policy JLCD- Administering Medicines to Students, 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.

**\*BE ADVISED:** It is the Parents/Guardians responsibility to claim students medication(s) by the last day of the school year. **Medication(s)** 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 medication sample **must** have a medication label to be administered at school.*

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication Name (one per form) \_\_\_\_\_ Dosage: \_\_\_\_\_

Route: \_\_\_\_\_ Frequency: \_\_\_\_\_ Times given at School: \_\_\_\_\_

Starting date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending date: \_\_\_\_/\_\_\_\_/\_\_\_\_ or until end of school year 2011-2012

Purpose of Medication: \_\_\_\_\_ Allergies: NKDA Other: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Office Phone: \_\_\_\_\_

**(Print)** Name of PCP or Dentist Prescribing Medication

Office Fax: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Clinic Name: \_\_\_\_\_

**Signature** of PCP w/Prescriptive Authority

**Medication Discontinued:** Time: \_\_\_\_\_ and Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ PCP Signature: \_\_\_\_\_

**\*\*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. Thank You!\*\***