

Student Medication Request and Release Agreement

Student: _____ **DOB:** _____ **School Year** _____

Name of Medication	Reason for Medication	Medication Dosage in MG	Route	Time(s) Medication to be Given
<input type="checkbox"/> Albuterol <input type="checkbox"/> Xopenex <input type="checkbox"/> _____	Asthma *Symptoms-(list): 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	<input type="checkbox"/> 2 Puffs <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> Inhaled <input type="checkbox"/> With Spacer	<input type="checkbox"/> Every 4 hours as needed for *symptoms <input type="checkbox"/> May repeat in _____ minutes <input type="checkbox"/> Prior to exercise
<input type="checkbox"/> Epinephrine Auto Injector* <i>*If Colorado State Anaphylaxis Health Care Plan is signed & completed by physician this form does not have to be completed</i>	Life threatening Allergies-(list): 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	<input type="checkbox"/> 0.15 mg <input type="checkbox"/> 0.3 mg	Intra-muscular (IM)	<input type="checkbox"/> Upon Exposure <input type="checkbox"/> Severe Reaction: Short of breath, wheeze, cough, pale, faint, dizzy, confused, tight throat, hoarse <input type="checkbox"/> Repeat if no improvement in 10 minutes
<input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> Other Antihistamine		<input type="checkbox"/> 12.5 mg <input type="checkbox"/> 18.75 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> 37.5 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> Other: _____ mg	By Mouth (PO)	<input type="checkbox"/> Upon Exposure <input type="checkbox"/> For MILD reaction: Itchy mouth, a few hives around mouth/face, mild itching, mild nausea/discomfort
		_____ mg		
		_____ mg		

Physician's Signature: _____ **Date:** _____

Prescribing Physician Name: _____ **Physician's Phone:** _____

School District Policy JLCD requires, as a condition to its agreement to release any medication, that the medicine be prescribed by a physician or dentist and furnished by the parent(s) of the student with the original pharmacy container label stating the student's name, name of the medication, the dosage, the number of dosages per day or time(s) when the medication is to be released to the student, and the date when the medication is to be stopped (if applicable). It is understood that the medication is given solely at the request of, and as an accommodation to, the undersigned parent(s) or guardian(s). The undersigned parent(s) or guardian(s) hereby agree(s) to release the Douglas County School District RE-1 and its personnel from any and all claim(s), which they now have or may hereafter have arising out of the release of the medication to the student.

Parent/Guardian Signature: _____ **Date:** _____

Reviewed/complete Needs clarification

School Nurse Signature: _____ **Date:** _____