COLORADO Early Colleges

Authorization to Administer Medication in School Form

Student's first name	Student's last name	Birth date

Prescription Medication

- If any prescription medication is to be administered during school hours, this form must be completed and signed by a health-care provider and parent/guardian. Prescription medications can only be given during school hours by the Health Office when an authorization form is on file with the School Nurse.
- A student's medication must be kept in the school's Health Office unless a physician specifies self-carry on this form.
- Medication must be provided by parent/guardian in the original container in which it was purchased. When ordering prescription medication, please ask the pharmacist to provide an additional empty, labeled bottle to be stored at school.

Over-the Counter Medication

- If any over-the-counter medication is to be administered by the Health Office during school hours, this form must be completed by the parent/guardian, HCP, and given to the school's RN.
- Responsible students may carry one day's dosage of over-the-counter medication in original packaging. This is a privilege and can be revoked.
- Medications must be kept on the authorized user's person and not shared with peers.

If a student is not carrying a one day dosage of the over-the-counter medication, but has a Medication Authorization form on file, the student can go to the school's Health Office. Health offices will have a limited supply of Acetaminophen, Ibuprofen, Hydrocortisone Cream, and cough drops.

Name of Medication (Prescription and Over-the-Counter)	
Dosage	
Route/Method	
Times Given If this is PRN, please specify dosage, amount per day, timing between doses	*Note to health-care provider: If this is PRN, please specify dosage, amount per day, and/or timing between doses.*
Purpose of Medication	*Note to health-care provider: Please do not say 'as needed', specify the reason to give this medication.*
Potential Side Effects	
Student to Self-Carry? ***(except for controlled substances)***	**{CIRCLE}** **YES NO**
End Date ***(if applicable)***	

Health-Care Provider Printed Name_____

Signature_____ Date_____

Parent/Guardian Printed Name_____

Signature_____ Date_____

School Nurse Signature_____ Date_____