MEDICATION AGREEMENT

Department of Health Services

Student Name:______________________________ Student Number:______________________________

School:______________________________ Grade/Teacher:______________________________

TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request and give my permission to the Jefferson County School District to administer medication to my child. I understand that it is my responsibility to proved the medication in the original pharmacy labeled container. I also understand the school may not alter or change any medications from their original form (cut or half pills, etc.)

Any prescription changes will require an additional signed and completed Medication Agreement.

Name of Student:______________________________ Date of Birth:______________________________

Medicaid? No Yes Medicaid Number:______________________________

Parent/Guardian Name:______________________________ Home/Work Phone:______________________________

Name of Medication:______________________________ Dosage:______________ Time:______________

Start Date:____________________ End Date:____________________ Route:____________________

I give my permission for the school staff to contact the prescribing physician regarding this medication.

______________________________ ______________________________
Signature of Parent/Guardian Date

TO BE COMPLETED BY PHYSICIAN (FOR PRESCRIPTION)

Patient's Name:______________________________ Date of Birth:______________________________

Medication:______________________________ Purpose:______________________________

Dosage:______________ Time(s) to be given at school:______________________________

Start Date:____________________ End Date:____________________ Route:____________________

Name of Physician:____________________ Office Phone Number:____________ Fax______________

______________________________ ______________________________
Signature of Physician Date

Only school employees who are trained and delegated by the Area Nurse Consultant may administer medication. The employee administering the medication must document the time they gave the medication in the appropriate box and then initial in the appropriate box.

Name of Area Nurse Consultant who trained and delegated:______________________________

Initials	Person Dispensing Medication	Title	Date Delegated

SUPPLEMENTAL MEDICATION LOG

Attach to the completed Medication Agreement (Form #924) for this medication.

Student Name:	Medication:
Student Number:	Dose #1 Start time:
Date of Birth:	Dose #2 Start time:

Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
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Initials					

Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
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#1 Time					
Initials					
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Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
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Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
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#1 Time					
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Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
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Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
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Week 1	Mon	Tue	Wed	Thu	Fri
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Week 1	Mon	Tue	Wed	Thu	Fri
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Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
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#2 Time					
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Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Jeffco Department of Health Services/Nursing Form 46-092400
Revised August 2008

Signature ANC:	Date:	Signature ANC:	Date:	Signature ANC:	Date: