Outdoor Education Provider Medication Authorization Form

Student: _____ **DOB:** _____ **School Year: 24/25**

(Schools do not provide any medications. Parents must send and anything purchased/ordered from the store/pharmacy must be listed in the medications below AND have Physician's Signature with dose and time of medication)

To be filled out by Medical Provider

Name of Medication	Reason for Medication	Medication Dosage & Strength	Route	Time(s) Medication to be Given
☐ Albuterol ☐ Xopenex ☐ Other Inhaler: _____	Asthma *Symptoms-(list): 1. 2. 3.	☐ 2 Puffs ☐ Other: _____	☐ Inhaled ☐ With Spacer	☐ Every 4 hours as needed for *symptoms ☐ May repeat in_____minutes if no relief (Notify RN) ☐ Prior to exercise
Tylenol (Acetaminophen) ***only given for fever if student is going home***	☐ Headache ☐ Menstrual cramps ☐ Musculoskeletal pain ☐ Toothache ☐ Other_____ ☐ Other_____	☐ 80 mg ☐ 160 mg ☐ 320 mg ☐ 325 mg ☐ 400 mg ☐_____	☐ Oral	☐ Every 4-6 hours as needed for ordered symptom

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

Prescribing Physician's 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 doses 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 claims), which they now have or may hereafter have arising out of the release of the medication to the student.

Parent Checklist:

☐ I have a Physician's Signature for all over the counter AND prescriptions.

☐ I have provided ALL medication in original packaging/prescription container.

☐ If prescription, it is in the original container with a prescription label. If over the counter, I will write the student's name on packaging.

☐ I will send medication that is not expired.

☐ I will send all non-emergency medication to the school **the Friday before departure**. Only lifesaving meds can be brought day of.

Please Choose:

☐My student may bring home all medications ☐A parent/guardian will pick up the medication from school during school hours

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

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

Return to Ben Franklin Academy via FAX to 303.974.1738 or Email to : health@bfacademy.org