Provider Medication Authorization Form

Student: _____ DOB: _____School Year:_____

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/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date:_____

☐ Reviewed/complete ☐ Needs clarification.

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