CSDB - Medication Administration Authorization
And Care Plan for Medication Administration

I _____, the parent, or legal guardian of
(Parent/Guardian name)
_____ request and authorize that the following
(Child's name)
medication _____be given to my child for _____
(Name of medicine and dosage) (Diagnosis)
at the following times(s) _____according to the Health Care Provider's signed instructions.

The Colorado School for the Deaf and Blind agrees to administer prescription and over the counter medication that is prescribed by a licensed health care provider. Health care provider written authorization and parent written authorization are necessary before medications may be administered by CSDB staff.

Prescription medications must come in a container labeled with student's name, name of medicine, time medicine is to be given, dosage, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication dosage must match the signed health care provider authorization, and medicine must be packaged in the original container.

1. I understand it is my responsibility to furnish the medication and maintain supplies, as needed, throughout the year, or until discontinued.
2. I will complete a new authorization every time there is a change of any kind regarding the medication, the information on this form, and/or the pharmacy label.
3. I agree to pick up expired or unused medication within one week of notification by staff. If I do not pick it up within 5 days, I will allow the authorized personnel to dispose of it.
4. I understand I am responsible for keeping a supply of medication at home for weekends. CSDB may not transport medications on a weekly basis.
5. By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Home Phone Emergency Phone

Health Care Provider Authorization to Administer Medication in School

Student's Name:_____ Birthdate: _____
Medication: _____ Diagnosis: _____
Dosage: _____ Route: _____
To be given at the following time(s): _____
Special Instructions: _____
Purpose of medication: _____
Side effects that need to be reported: _____
Starting Date: _____ Ending Date: _____
☐ _____Student has been instructed and is capable of self administration of this medication

_____ _____
Signature of Health Care Provider with Prescriptive Authority License Number

_____ _____
Phone Number Date

Complete One Form for EACH Medication