ARAPAHOE CHARTER SCHOOL
AUTHORIZATION OF MEDICATION

TO BE COMPLETED BY PHYSICIAN/MEDICAL PROVIDER

Date: _____
Name of Student: _____ Date of Birth: _____

In order to keep this student in optimum health and to help maintain school performance, it is necessary that medication be given during school hours.

Medication: _____ Dosage (mg): _____
Route of Medication: _____ # of tablets: _____
Time(s) to be given at school: _____
Providers please note that "lunch time" can vary from 10:30 to 1:00 PM

FOR ASTHMA INHALERS, INSULIN USERS, AND EPINEPHRINE AUTO-INJECTORS ONLY:

_____ May self medicate (student has demonstrated proficient use of medication)

_____ May NOT self medicate

If medication is ordered as needed, please indicate specific circumstances when the medication should be given (school staff, not health care professionals, will be administering the medication): _____.

Please describe any side effects the teacher should look for when administering the prescribed medication: _____.

Medical Provider's Signature: _____ Telephone #: _____

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TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby give my permission for my child, _____, to receive medication during school hours. A licensed physician has prescribed this medication. I hereby release Arapahoe Charter School and their agents and employees from any and all liability that may result from my child taking the medication.

Signature of Parent/Guardian: _____ Date: _____

Phone number: _____ Emergency Contact: _____