

HEALTH SERVICES
Douglas County School District Re.1

312 Cantril St. Rm 201

303-814-5363

Castle Rock, CO 80104

MEDICATIONS AT SCHOOL (Elementary)

1. Most medications are available in long acting form and parents are encouraged to administer such medication at home to avoid administration at school.
2. Only prescription medication and acetaminophen (Tylenol) may be used at school. **Over-the-counter medication will not be allowed at school unless a doctor's written authorization is provided.**
3. Prescription medication will be released to students at school only on the specific written request of the student's parent or guardian and with the written authorization of the student's physician. (See the enclosed form). The need for both parent and physician authorization is a state regulation. All prescription medication must be furnished in the original pharmacy labeled container. Over-the-counter medications must be in the original pharmaceutical bottle.
4. Acetaminophen (Tylenol) will be available in the health room at each elementary school. Dr. Jay Rabinowitz, a pediatrician in Parker, has developed a protocol for the school personnel informing them of the conditions under which acetaminophen may be released and the proper dosage for each age level. Designated school personnel may release acetaminophen to students with the following symptoms, providing prior written parental permission has been given:
 - headache
 - toothache
 - dysmenorrhea (menstrual cramps)
 - musculoskeletal pain (i.e. back pain, leg pain)
 - fever (100 F or above) only after the parent has been notified to pick up student

Permission for administration of acetaminophen is on the student registration form. The permission must be signed if you wish your child to receive acetaminophen for any of the above health problems. You will be notified if she/he has taken acetaminophen during the school day.

5. A parent may bring medication in during school hours. Medication sent with the student must be in the original pharmacy (or pharmaceutical) bottle and placed in a sealed envelope. If the medication arrives without the sealed envelope, the parent will be contacted and the student may be subject to disciplinary actions.

**DOUGLAS COUNTY SCHOOL DISTRICT Re. 1
SCHOOL HEALTH SERVICES**

STUDENT MEDICATION REQUEST RELEASE AGREEMENT

The undersigned parent(s) or guardian(s) of: _____
hereby request personnel employed by the Douglas County School District Re. 1 to release to said
child (name of medicine) _____ at (time) _____ as
described below by the prescribing physician.

School District Policy JLCD requires, as a condition to its agreement to release any medication,
that the medicine has been prescribed by a physician or dentist and that it has been furnished by the
parent(s) of the student with the original pharmacy container label stating the child's name, name of
the medication, the dosage, the number of dosages 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 claim(s) which
they now have or may hereafter have arising out of the release of the medication to the student.
A new form must be completed for all medication changes.

DATE _____

Parent/Guardian Signature School Child Attends

The undersigned requests that the above listed medication be released to said child in accordance
with these instructions.

Name of Physician or Dentist Prescribing Medication Physician's Telephone Number

Physician's Printed Name

Physician's Address

(Do Not Cut)

PHYSICIAN'S SIGNED ORDER FOR MEDICATION

This form must be completed for any medication (prescription or non-prescription)
a student will need to take during school hours.

Student's Name _____ Medication _____

Route of Administration _____ Dosage _____ Time _____

Start Date _____ Discontinue Date _____
(All medications expire at end of school year.)

Purpose of Medication(s) _____

Side Effects of Particular Concern _____

Physician's Signature _____ Date _____