

**Authorization to Administer Medication**

Reference: Policy # 2240

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**A new authorization form must be completed at the beginning of each school year and each time there is a change in dosage or time of administration.**

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Parents or guardians are requested to be present to administer any necessary medication to their children whenever possible. If a parent or guardian of the child is unable to be present to administer any necessary medication only a designated trained staff member may administer the medication. No medication, including aspirin, cough and cold medication, decongestants, or other over-the-counter or prescription medications shall be administered by any Registered Nurse (RN) or trained delegated school personnel except under the following conditions:

1. Written instructions from the child's Licensed Authorized Prescribing Practitioner (LAPP) must be provided, and must state the following:
  - ✓ The child's name
  - ✓ The name of the medication;
  - ✓ The proper dosage and route of the medication;
  - ✓ The purpose of the medication;
  - ✓ The time of day/circumstances in which the medication is to be administered;
  - ✓ The anticipated number of days the medication must be administered; and
  - ✓ Any possible side effects of the medication.
  
2. Any medication must be brought in a container appropriately labeled by a pharmacy or the child's LAPP and must be picked up by an adult after the designated time period or it will be discarded. *Please ask the pharmacist for a separate labeled medicine bottle to keep at school.*

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Child's Name (Printed) \_\_\_\_\_

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Date \_\_\_\_\_

By signing this document I give permission for my child's LAPP to share information about the administration of this medication and the child's health care condition with the school staff designated to administer medication. I hereby authorize an RN any trained delegated school personnel to administer medication to my child according to the written instructions of the child's LAPP and certify that the above conditions have been met in their entirety.

I release the Archdiocese of Denver, RN and any trained delegated staff members from liability for any adverse reaction suffered by my child as a result of the administration of medication to my child in accordance with the written instruction of the child's LAPP. I agree to indemnify the Archdiocese of Denver and any trained delegated staff members for any medical expenses, legal expenses, or liability related to any adverse reaction suffered by my child as a result of the administration of (name of medication) \_\_\_\_\_  
 \_\_\_\_\_ to my child in accordance with the written instruction of the child's LAPP.

I have carefully read this Authorization to Administer Medication, and I understand and agree to each of the covenants and conditions set for above. This Authorization to Administer Medication is effective for \_\_\_\_\_ (state the relevant time period, such as one day or one week, up to one year for chronic conditions), unless earlier revoked.

\_\_\_\_\_  
*Parent or Guardian (Print Name)* \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Parent or Guardian*

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_