Granite District School Nurse Services
School Medication Authorization Form

Date _____

Name of Child _____ School _____ Birth Date_____ Grade ___

To be completed by Healthcare Provider:
This order can only be signed by Physician (MD,DO), Dentist, Nurse Practitioner (NP, FNP, PNP, APRN/PP), or Certified Physician's Assistant.

Diagnosis _____

Medication _____

Dose _____ Time _____ Route _____

Reportable adverse reactions / side effects _____

_____

Medication Self-Administration Authorization: [ ] Yes [ ] No
The above named student is under my care. I feel it is medically appropriate and the student is trained and capable to carry and self-administer the following indicated medication at all times:

[ ] Inhaler [ ] Insulin Pen [ ] Epi-Pen

Name of healthcare provider _____ Phone _____

Healthcare provider signature _____ Date _____

Parental Responsibilities:

- The medication is to be furnished by the parent and brought to the school in the current original container, labeled with the child's name, medication name, time, dosage, and healthcare provider's name.
- All medications must be delivered to the school by an adult and picked up by an adult within two weeks of last dose given.
- If there is a change in the prescription, a new parent consent form and a new healthcare provider's order must be completed before the staff can administer the new medication.

I understand that by signing this form I am giving permission to the school nurse to contact the healthcare provider if clarification is needed for administering of the medication listed above. I am willing to meet parental responsibilities. School personnel will administer only the medication listed above.

Parent Signature _____ Date _____

Phone Number _____ Emergency Number _____

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