*** * NOT TO BE USED FOR ASTHMA MEDICATION. PLEASE REQUEST AN ASTHMA ACTION PLAN. * ***

GATEWAY REGIONAL HIGH SCHOOL MEDICATION FORM

PARENTAL PERMISSION

Please administer the enclosed medication to my child during school hours. I understand that the medication must be in its original container. I release GRHS from all liability that my occur as a result of the used of this medication or the self administration of approved medications by my child. The School Nurse has my permission to contact my child's Health Care Provider if there is a question concerning this medication.

Student's Name: _____ Grade: _____

Medication and dosage: _____

Parent/Guardian Signature: _____ Date: _____

PHYSICIAN, DENTIST, ADVANCED PRACTICE NURSE, OR PHYSICIAN'S ASSISTANT AUTHORIZAION

Student's Name: _____

Medication and Dose: _____

Reason for medication: _____

Side Effects: _____

Medication Allergies: _____

If this medication is for a life threatening condition such as anaphylaxis, diabetes, or asthma, may the student self administer this medication? Yes _____ No _____

The above student is under my care for the above condition. I authorize the School Nurse to administer the ordered medication as prescribed.

Health Care Provider's Printed Name: _____

Address: _____

Phone Number: _____

Signature: _____ Date: _____

NOTE: **This form is also required for all over the counter medication. Please use a separate form for each medication needed.**

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