

**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 may occur as a result of the use 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 AUTHORIZATION**

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.**