Medication Administration - Authorization Form

Ganado ISD - Student Health Services

GISD does not provide any medications for students. For students to be medicated **PARENTS MUST PROVIDE** the medication, including over the counter medications such as Tylenol, Motrin, Benadryl, Cough Suppressants, etc. Medications must be provided in the current and original container. All medication must be stored in the nurse's office unless the student is cleared by both the **physician** and school nurse to self-carry (see "Self-Carry Authorization Form"). Medications that are EXPIRED will not be administered. **Both the PARENT & LICENSED PROVIDER (MD, DO, PA, NP) must sign this form in order for any medication to be administered by the nurse or other school personnel.**

Student Name: ______________________ Grade: __________ DOB: ______________

Medication Allergies: ______________________________

Medication: ______________________ Dosage (mg): __________ Route: __________

☐ Routine (Daily):

Condition for which the medication is required: ______________________

Dates to be Administered: __________ to __________ **OR** ☐ Entire School Year

☐ PRN (As Needed):

Indications: ______________________

May Repeat PRN Dose After: __________

Medication: ______________________ Dosage (mg): __________ Route: __________

☐ Routine (Daily):

Condition for which the medication is required: ______________________

Dates to be Administered: __________ to __________ **OR** ☐ Entire School Year

☐ PRN (As Needed):

Indications: ______________________

May Repeat PRN Dose After: __________

Medication: ______________________ Dosage (mg): __________ Route: __________

☐ Routine (Daily):

Condition for which the medication is required: ______________________

Dates to be Administered: __________ to __________ **OR** ☐ Entire School Year

☐ PRN (As Needed):

Indications: ______________________

May Repeat PRN Dose After: __________

Parent Authorization:

I authorize the provider named below to release information regarding medication(s) my child will take during school hours to GISD Student Health Services. I request that the designated personnel of GISD administer medication to my child, named above, according to written provider's instructions and for the school nurse to exchange information with the provider regarding medical and health related issues. I understand it is my parental responsibility to furnish an adequate supply of this medication in the original and properly labeled container. I will notify the school immediately if the health status of my child changes, we change physicians, or the medication is changed or canceled. I understand the school district personnel will protect my child by not administering the medication if this form is not complete or the prescribed medication is not provided.

Printed Name: ______________________ Phone: ______________

Signature: ______________________ Date: ______________

Licensed Primary Care Provider (MD, DO, NP, PA) Authorization:

Provider's Name: ______________________ Signature: ______________

Phone Number: ______________ Fax: ______________ Date: ______________