

GARDEN CITY PUBLIC SCHOOLS

Garden City, MI 48135

MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid from (School Year): September 1, _____ through August 31, _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the school.
- The school will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

PRESCRIBER'S AUTHORIZATION (use one form for each medication)

Name of Student: _____

Date of Birth: _____ Grade: _____ School Building: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____

Route: _____ Time/frequency of administration: _____

If PRN, frequency: _____, for what symptoms: _____

Relevant side effects: None expected Specify: _____

Type or Print Prescriber's Name/Title: _____

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____

(Original signature or signature stamp ONLY)

(Use for Prescriber's Stamp)

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school to communicate with the health care provider as allowed by HIPAA. I/We will not hold the Board of Education or its personnel responsible for complications related to the medication pursuant to P.A. 451 or 1976-S1178.

Parent/Guardian Signature: _____ Date: _____

Cell Phone #: _____ Work Phone #: _____

SELF-CARRY/SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION

Self-carry/self-administration of medication (including emergency medication) may be authorized by the prescriber and must be approved by the school according to the school medication policy.

Prescriber's authorization (sign and date): _____

School representative approval (sign and date): _____

Order reviewed by the school (sign and date): _____

Signature of Reviewer and Date