Grand Meadow Public School
Licensed Prescriber Annual Authorization for Medication

School Year _____ (Must be renewed annually)

Student Name: _____ DOB: _____

ADMINISTRATION OF MEDICATION AT SCHOOL REQUIRES:

- The licensed prescriber's order (MD, PA, CNP, DDS) for prescription medication and for over-the-counter medication at doses that **exceed** the recommended dose on the label.
- Prescribed medication **must** be in a pharmacy labelled container. (The pharmacy can provide medication in separate containers for school and home.)
- Provider orders are effective throughout the school year, summer school and through September 30th of the following school year unless the orders are discontinued or changed by the provider or withdrawn in writing by the parent before that time elapses.

DAILY MEDICATIONS

Name of Daily Medication (Generic and Trade Name)	Dose	Route	Time/Frequency
Diagnosis/medical reason for medication:			
Name of Daily Medication (Generic and Trade Name)	**Dose**	**Route**	**Time/Frequency**
Diagnosis/medical reason for medication:			

PRN MEDICATIONS

Name of Daily Medication (Generic and Trade Name)	Dose	Route	Time/Frequency
Diagnosis/medical reason for medication:			
Name of Daily Medication (Generic and Trade Name)	**Dose**	**Route**	**Time/Frequency**
Diagnosis/medical reason for medication:			

OTC MEDICATIONS

Name of Daily Medication (Generic and Trade Name)	Dose	Route	Time/Frequency
Diagnosis/medical reason for medication:			
Name of Daily Medication (Generic and Trade Name)	**Dose**	**Route**	**Time/Frequency**
Diagnosis/medical reason for medication:			
Name of Daily Medication (Generic and Trade Name)	**Dose**	**Route**	**Time/Frequency**
Diagnosis/medical reason for medication:			

Licensed Prescriber Authorization: *I am prescribing the following medication(s) for the above student to be administered at school.*

Licensed Provider Printed Name: _____ Date: _____

Licensed Provider Signature: _____ Date: _____

Clinic: _____ Phone/Fax: _____

Parent Permission:

- ❑ I request that authorized personnel at the Grand Meadow School assist my child in taking prescribed medication(s) as ordered by his/her prescriber, and/or in taking over-the-counter medication(s) as designated by his/her licensed prescriber.
- ❑ I give permission for school personnel to communicate with the licensed prescriber regarding use, side effects, response, and contraindications of the medication(s).
- ❑ I request that my child be allowed to self-carry and self-administer emergency medication that may be necessary to treat health conditions. I understand that the school nurse will assess my child's ability to safely do so by reviewing the Student Self-Carry and Self-Administer Checklist with my student.
    - I shall hold harmless and indemnify the Grand Meadow School District, its agents, employees, and board members against all claims, judgements, or liability arising out of self-administration and carrying of medication by my child.
- ❑ I confirm that my child has previously taken this medication.
- ❑ My child has not previously taken this medication, but this is an emergency medication.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____