PHYSICIAN'S AUTHORIZATION for PRESCRIPTION MEDICATION at SCHOOL w/Release

This order expires on _____ or at the end of the current school year.

Student's Name: _____ Date of Birth: _____

Diagnosis: _____

Medication: #1 _____ Dosage (mg, ml, puffs): _____

Specify medication type: □ Daily □ Emergency □ As Needed

Form of medication (circle): Pill/Capsule Liquid Inhaler Nebulizer Injection Topical Drops

Time to be given at school:_____ If prn, allowable frequency: _____

Special requirements with medication: _____

Side effects of medication:_____

Medication: #2 _____ Dosage (mg, ml, puffs): _____

Specify medication type: □ Daily □ Emergency □ As Needed

Form of medication (circle): Pill/Capsule Liquid Inhaler Nebulizer Injection Topical Drops

Time to be given at school:_____ If prn, allowable frequency: _____

Special requirements with medication: _____

Side effects of medication:_____

_____ _____ _____

Physician's Name (print) Physician's Signature Date

PARENT'S PERMISSION

MEDICATION MUST BE IN ORIGINAL CONTAINER

I hereby request that my child (named above) receive medication during school hours per the physician's order and the GLPS medication policy. I will not hold the GLPS Board of Education or its personnel responsible for complications related to the medication. Permission to administer medications expires at end of school year.

_____ _____

Parent Signature Date

GRAND LEDGE PUBLIC SCHOOLS DO NOT HAVE MEDICAL PERSONNEL PRESENT TO ADMINISTER MEDICATION/ TREATMENT, IF APPROPRIATE, PLEASE ORDER MEDICATION/ TREATMENT TO BE ADMINISTERED AT HOME.

All medication must be delivered to the school office by a parent/guardian or an adult parent representative in the original, properly labeled container

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EXCHANGE OF HEALTH INFORMATION/RECORDS between Grand Ledge Public Schools & provider listed below

PURPOSE: Health assessment and planning for healthcare services and treatment in school, medical evaluation and treatment

This authorization is valid for one calendar year. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district may not be protected by the HIPAA Privacy Rule but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's care at school.

Name of School: _____ Address:_____

Phone Number: _____ Fax number:_____

Physician's Name:_____ Address:_____

Phone Number: _____ Fax Number: _____

_____ _____

Parent/Guardian Signature Date