# SCHOOL MEDICATION PRESCRIBER AUTHORIZATION

Gardendale Christian Academy

## STUDENT INFORMATION

Student's Name _____

Grade _____ Teacher _____

List any drug allergies/reactions _____

_____

## PRESCRIBER AUTHORIZATION

Name of Medication _____ Reason for taking_____

Dosage _____ Route _____ Frequency/Time(s) to be given _____

Start administration of medication beginning _____ Discontinue _____
Date Date

Special Instructions:

| | | |
|---|---|---|
| Does medication require refrigeration? | Yes { } | No { } |
| Is the medication a controlled substance? | Yes { } | No { } |
| Is self-medication permitted and recommended for this student? | Yes { } | No { } |
| If asthma inhaler or emergency medication, do you recommend this medication be kept "on person" by the student? | Yes { } | No { } |
| Is this an OTC medication? | Yes { } | No { } |
| Is this OTC sunscreen? | Yes { } | No { } |

Potential side effects/contraindications/adverse reactions _____

_____

_____

Treatment order in the event of an adverse reaction: (attach additional sheet of use back of this form if necessary) _____

_____

_____

_____

_____ _____ _____
Signature of Prescriber Date Phone

## PARENT AUTHORIZATION

I authorize school personnel to assist my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Medication should be registered with the principal, his/her designee, or the school nurse. It should be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate.

_____ _____ _____
Signature of parent or guardian Date Phone

I authorize and recommend self-medication by my child for the above medication.

_____ _____ _____
Signature of parent or guardian Date Phone