HOWARD GARDNER
MULTIPLE INTELLIGENCE CHARTER SCHOOL

Health Care Provider Authorization for Medication in School

PLEASE FILL OUT ONE SHEET PER MEDICATION AND CHILD

Child's Name: _____ D.O.B: _____

Medication: _____

Dosage: _____ Route: _____

To be given at the following time(s): _____

If PRN indication for giving: _____

Indications for this medication: _____

Side effect that need to be reported: _____

Starting Date: _____ End Date: _____

Other medication used outside of school _____

_____ _____
(signature of health care provider) (license number)

_____ _____
(phone number) (date)

SEE BACK

1615 East Elm Street *Scranton, PA 18505* *Tel: (570)941-4100*
www.howardgardnerschool.com

Updated 5/1/2020

HOWARD GARDNER
MULTIPLE INTELLIGENCE CHARTER SCHOOL

Parent/Guardian Authorization for Medication in School

PLEASE FILL OUT ONE SHEET PER MEDICATION AND CHILD

The Parent/Guardian of_____
(Child's name)

ask that the school nurse or principle/principal's designee administer medication as ordered

_____

_____
(Name of medication and dosage)

Medication Expiration Date: _____

At the following time(s): _____

- **Prescription Medications** must be delivered to the school by the parent/guardian and be in the original container labeled with the name of the medicine to be given, dosage, date of medicine is to be stopped, and the licensed health care provider's name. The pharmacy name and phone number must also be included on the label.
- **Over the Counter, Medications** must be labeled with the child's name. The medication dosage must match the signed health care provider's authorization and it must be delivered to the school by a parent/guardian in the original package.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the school nurse, principal, and/or principal designee. As the parent/guardian of the above-named child, I relieve Howard Gardner Multiple Intelligence Charter School and all employees of any responsibility for the benefits or consequences of this medication.

_____ _____
Parent/Legal Guardian's Signature Date

HOWARD GARDNER
MULTIPLE INTELLIGENCE CHARTER SCHOOL

Health Care Provider Authorization Administer Asthma Inhalers and/or Epinephrine Auto-Injectors

PLEASE FILL OUT ONE SHEET PER MEDICATION AND CHILD

Child's Name: _____ D.O.B: _____

Medication: _____

Dosage: _____ Route: _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of this medication: _____

Side effect that need to be reported: _____

Is the student qualified and able to self-administer this medication: ___Yes ____No

Starting Date: _____ End Date: _____

Other medication used outside of school _____

_____ _____
(signature of health care provider) (license number)

_____ _____
(phone number) (date)

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Authorization to Administer Asthma Inhalers and/or Epinephrine Auto-Injectors

PLEASE FILL OUT ONE SHEET PER MEDICATION AND CHILD

The Parent/Guardian of: _____ (child's name)
Give permission for my child to carry and self-administer the following medication.

Medication: _____

_____

Medication Expiration Date: _____

At the following Time(s): _____

As a parent/guardian of the above-named child I relieve Howard Gardner Multiple Intelligence Charter School and all employees of any responsibility for the benefits or consequences of the prescribed medication. I also acknowledge that the Howard Gardner Mi Charter School will bear no responsibility in ensuring that the medication was taken. I understand that carrying an asthma inhaler or epinephrine auto-injector is a privilege to my child. The loss of this privilege will be enforced if the school policy pertaining to such self-administration is abused and/or ignored.

By signing this document, I give my permission for my child's health care provider to share information and the administration of this medication with the school nurse.

_____ _____

Parent/Legal Guardian's signature Date