



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): _____

Special Instructions: _____

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)



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



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