GLENDALE RIVER HILLS SCHOOL DISTRICT

Medical Provider Permission

Student's Name: _____ Doctor's Name: _____

Assigned School: _____ Grade: _____ Date of Birth: _____

I am prescribing the following medication and procedures for the above student to be administered or performed at school.

DAILY

Name of Daily Medication	Dosage and Frequency	Time(s) *(am/pm)*	Start Date	Stop Date	Possible Adverse Side Effect of Contraindications

PRN

Name of PRN Medication	Dosage and Frequency	Time(s) *(am/pm)*	Start Date	Stop Date	Possible Adverse Side Effect of Contraindications

Name of Procedure *(catheterization, glucose checks, suctioning, etc.)*	Dosage and Frequency	Time(s) *(am/pm)*	Start Date	Stop Date	Monitoring Parameters

The above orders shall be effective throughout the current school year, summer school and through September 30th of the following school year, unless the orders are discontinued, changed or withdrawn in writing by the parent/guardian before that time elapses.

Medical Provider's Signature	Date (Month/Day/Year)	Telephone/Fax Number
Parent Signature	Date (Month/Day/Year)	Telephone/Fax Number