Garden City Public Schools
Garden City, MI 48135

MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid from (school Year):September 1,_____ through August 31,_____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in the dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the school.
- The school will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

PRESCRIBER'S AUTHORIZATION(use one form for each medication)

Name of Student:_____
Date of Birth:_____Grade:_____School Building:_____
Condition for which medication is being administered:_____
Medication Name:_____Dose:_____
Route:_____Time/frequency of administration_____
If PRN, frequency:_____, for what symptoms:_____
Relevant side effects:___None expected_____Specify_____
Type or Print Prescriber's Name/Title:_____
Telephone:_____FAX:_____
Address:_____
Prescriber's Signature:_____
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PARENT/GUARDIAN AUTHORIZATION

I/We request designate school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school to communicate with the health care provider as allowed by HIPAA. I/We will not hold the Board of Education or its personnel responsible for complications related to the medication pursuant to P.A. 451 or 1976-S1178.

Parent/Guardian Signature:_____Date:_____
Cell Phone #:_____Work Phone:_____
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SELF-CARRY/SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION

Self-carry/self-administration of medication (including emergency medication) may be authorized by the prescriber and must be approved by the school according to the school medication policy.
Prescriber's authorization sign and date):_____
School representative approval (sign and date):_____
Order reviewed by the school (sign and date):_____
Signature of Reviewer and Date