SUSAN GRAY SCHOOL

PROVIDER ORDER /MEDICATION AUTHORIZATION FORM

Student Name: _____ DOB: _____

. . . . . .

PROVIDER ORDER **(Please complete every item in this section)** **Effective Dates: _2022/23 School Year_**

1. I have examined this student for (diagnosis**)**_____and have determined that he/she **requires** medication during school hours.

2. Name of Medication:_____ Dosage: _____
   Route: _____ Time of administration: _____ Duration: __**2022/2023 School Year**__

3. Special instructions regarding this medication: _____
   _____
   _____

4. Contact me if the following signs or symptoms develop: _____

Healthcare Provider Signature: _____Printed Name: _____

Phone: _____ Fax: _____ Email: _____

. . . . . .

PARENT/GUARDIAN STATEMENT: **(This document is in effect for the current school year only)**

1. I, the undersigned parent/guardian of the above named student, hereby request the school nurse or designee administer the above medication according to the healthcare provider's instructions (above).
2. I agree to furnish the necessary prescribed medication in the properly labeled container, to provide replacement medication as necessary and to notify the school nurse immediately if the provider or medication prescription is changed or discontinued.
3. I authorize, as needed, the sharing of information related to my child's health between the school nurse (and designee) and the health care provider listed on this form. I understand without this authorization to communicate these orders will not be implemented.

Parent/Guardian Signature: _____ Date: _____

***only one medication per form**
***Plan is effective for 2019/2020 school year unless other date is noted. If changes need to be made to current plan, a new form will need to be submitted and this plan will become ineffective.**

For Office Use Only Medication expiration date: _____

Medication discontinued date: _____ by ☐parent ☐provider (If parent provider notified: (_____) date