



Gibraltar School District -- Nursing Services, 19370 Vreeland, Woodhaven, MI 48183

Phone: (734) 379-6365 Fax: (734) 379-6366

**CARLSON HIGH SCHOOL**

**PERMISSION TO ADMINISTER MEDICATION**

**2019-2020**

STUDENT: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

TEACHER: \_\_\_\_\_ GRADE: \_\_\_\_\_

I hereby request that my child be administered his/her prescribed medication by the designated school personnel. I understand that the medication will be administered per the physician's order as outlined below. I understand that a doctor's signature, dosage and frequency are mandatory for prescription medications as well as for over-the-counter medications. I understand that medication will only be administered from the original prescription container with this child's name indicated. (Over the counter medications must be in a new unopened original container and labeled by the parent with the child's name and instructions.) I will provide a new PTAM form if any changes or discontinuation of any medication is needed. I give the school nurse permission to discuss or clarify the following order with my child's physician.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Legal Guardian)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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**For Inhalers and/or Epi Pens:    Student May Self-Carry    Student May Self-Administer**

I request my child be allowed to carry his/her Inhaler and/or Epi Pen (Circle which is applicable to use as needed at school as ordered by his/her physician.

I agree to ensure that my child will carry the above mentioned medication in a responsible manner. Misuse may revoke these privileges.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Legal Guardian)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Child)

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**PHYSICIAN'S DIRECTIONS**

1. **Name and strength of Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_

**Frequency:** \_\_\_\_\_ **Route:** \_\_\_\_\_

**Reason for medication, symptoms:** \_\_\_\_\_

2. **Name and strength of Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_

**Frequency:** \_\_\_\_\_ **Route:** \_\_\_\_\_

**Reason for medication, symptoms:** \_\_\_\_\_

**Physician's (Printed) Name:** \_\_\_\_\_ **Ph. #:** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_  
(Parent's initials) Any medication not picked up by the parent at the end of the school year will be disposed of properly.