GATEWAY SCIENCE ACADEMY
ST. LOUIS

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AUTHORIZATION OF MEDICATION AT SCHOOL

Student:_____ Date of Birth:_____

PARENT/GUARDIAN PLEASE READ and COMPLETE THIS PORTION

●I request the listed medication be given as ordered by the licensed healthcare professional.

●I give health services staff permission to communicate with the medical office about this medication.

●I understand certain medication may be administered by non-licensed staff members who have been trained and are supervised by a registered nurse.

●I understand medication information may be shared with all school staff working with my child and emergency staff, if necessary.

●All medication must be brought to the school in the original pharmacy or manufacturer labeled container with instructions for administration.

●I request and authorize my child to carry and or self-administer their medication (only for albuterol or epi pens) □Yes □No

PARENT SIGNATURE_____ DATE_____

ONLY A LICENSED HEALTHCARE PROVIDER MAY COMPLETE THIS PORTION

Medication Name	Reason for Medication	Dosage	Method	Time(s) to be Taken

●I request and authorize this student to carry and self-administer medication: □ Yes □ No

●I request the above medication be administered from _____ to _____ (not to exceed current school year)

Name of licensed healthcare professional (please print)_____

Signature of licensed healthcare professional_____ Date_____

Contact Number _____