Gallatin Gateway School District

STUDENTS 3416F2

PERMISSION FOR MEDICATION TO BE GIVEN AT GALLATIN GATEWAY SCHOOL

PLEASE PRINT CLEARLY

STUDENT NAME: _____ GRADE: _____

TEACHER: _____

DIAGNOSIS: _____

MEDICATION: _____ DOSAGE: _____

PURPOSE OF MEDICATION: _____

TIME OF DAY MEDICATION IS TO BE GIVEN: _____

POSSIBLE SIDE EFFECTS: _____

_____

ANTICIPATED NUMBER OF DAYS IT NEEDS TO BE GIVEN AT SCHOOL: _____

ADDITIONAL INSTRUCTIONS: _____

_____

_____

_____ _____

(DATE) (SIGNATURE OF HEALTH CARE PROVIDER)

I hereby give my permission for _____to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication. I authorize the release and exchange of information concerning this medication between the school and this physician.

_____ _____

(DATE) (SIGNATURE OF PARENT/GUARDIAN)

**NOTE:* *The prescription medication is to be brought to school in a container appropriately labeled by the pharmacy or Health Care Provider, stating the name of the student, the name of medication, and the dosage.*

Policy History:

Adopted: March 30, 2006

Revised: