



## Authorization for Prescription Medication and/or Treatment at School

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of School: \_\_\_\_\_ School Year: \_\_\_\_\_

Name of healthcare provider ordering the medication and/or treatment: \_\_\_\_\_

Contact information of healthcare provider (phone): \_\_\_\_\_

Medication: \_\_\_\_\_

Name	Dosage	Route	Frequency/Time
------	--------	-------	----------------

Treatment: \_\_\_\_\_

Description	Frequency/Time
-------------	----------------

Reason for medication or treatment (medical diagnosis): \_\_\_\_\_

Reason for medication/treatment (medical diagnosis): \_\_\_\_\_

I hereby give my permission to the school nurse to give the medication or perform the treatment to my child according to the written healthcare provider orders. If deemed appropriate, the nurse may delegate this nursing task to unlicensed assistive personnel who have received training and an evaluation of competence and have agreed to ongoing supervision by the nurse.

I also give permission to the school nurse to:

- Release information related to the health services to the prescribing healthcare provide
- Request information from the prescribing healthcare provider.
- I further agree to hold the Geist Montessori Academy school district harmless in any or all claims arising from the administration of this medication or the performance of this treatment at school.

I agree to notify the school nurse in writing (1) when I wish to withdraw this medication administration and/or treatment authorization and (2) when any change in the above healthcare provider orders for medication administration or treatments at school change.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date