Grand Traverse Academy
2145 Hammond Road East
Traverse City, MI 49686
(231) 995-0665 / Fax (231) 995-0880

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Name of Student _____ Birth Date _____

Class_____ Teacher_____ Date Received by GTA _____

PHYSICIAN'S ORDER

(to be completed by physician or authorized prescriber)

Diagnosis/Purpose of Medication _____ / _____

Name of Medication_____ Dosage _____

❑ Tablet/capsule ❑ Liquid ❑ Inhaler ❑ Injection ❑ Nebulizer ❑ Other _____

Frequency _____ Time of Day _____ Anticipated Duration _____

This Prescription Is: ❑ Initiation of Therapy ❑ Adjustment of Dosage
❑ Maintenance Dose ❑Discontinuation of Therapy

Important Side Effects or Restrictions_____

START: ❑ Date Form Received ❑Other_____
❑ For Episodic/Emergency Events Only

STOP: ❑ End of School Year ❑Other_____

Special Storage Requirements ❑None ❑Refrigerate ❑Other_____

Physician's Signature _____ Phone _____ Date _____

Physician's Name _____ Address_____

The undersigned parent/guardian authorizes Grand Traverse Academy, through its office staff, building level principal or secretary, to administer medication or to supervise the taking of medication by his or her child. It is understood that the undersigned parent/guardian shall immediately notify the school district in writing in the event that the prescription shall be discontinued or modified.

The medication must be brought to school by a parent/guardian in the original pharmacy bottle, appropriately labeled. The medicine must be kept locked in the school office. Refill of the prescription shall be the responsibility of the parent/guardians.

Further, the undersigned releases the school district and shall indemnify said school district from any liability or damage which may result to the student from the administration of said medicine as prescribed by the physician.

Parent/Guardian Signature_____Date _____

Home Phone_____ Daytime Phone_____