GRAND FORKS PUBLIC SCHOOLS
Medication Authorization Form

Student's Name:	**Grade:**

Instructions provided by your health care provider are required in order for your child to take medication at school. Please ask your health care provider to complete and sign the section below.

To be completed by a health care provider:

Any known allergies: _____

In the absence of trained medical personnel, I hereby authorize any unlicensed person who has successfully completed medication training with certification, to administer the following medication in the school setting:

Medication	Dose	Time	Directions

Health care provider signature: Date:	Parent/Guardian signature: Date:

Emergency Medication Possession and Self-Administration Approval:

Student may carry and has received instruction in self-administration and proper handling of emergency medication.

Please indicate the approved medication: ☐ Inhaler ☐ Epinephrine ☐ Other _____

Health care provider signature: Date:	Parent/Guardian signature: Date:

KEEP THIS FORM WITH THE MEDICATION