

Granby Public Schools
Medication Order

Name of Student: _____ DOB: _____ Grade: _____

Medication: _____ Dose: _____ Route: _____

Time Given at School: _____ Start Date: _____ End Date: _____

Diagnosis: _____ Allergies: _____

Other Medications Taken By Student: _____

Name of Prescriber (Please print) _____ Phone: _____

Prescriber Address: _____

Prescribing Provider Signature: _____ **Date:** _____

*Please note that if benadryl is ordered to be given prior to an epipen, the epipen will be given first if there is no RN within the school building or on the field trip.

Please note that both the top and bottom portion of this form MUST be complete to be a valid order for Granby Public Schools

Parent/Guardian Consent

I give my permission to have the school nurse or school staff designated by the nurse, administer the medication on this order form to the above named student. Yes ___ No ___

I give permission for the school nurse to share with appropriate school staff, after school activities coordinator, Jr/Sr high school athletic director, and local emergency medical services information relative to the prescribed medication. Yes ___ No ___

I give designated school personnel (as deemed by the school nurse) permission to administer this medication on a field trip during this school year (not applicable for all medications). (This includes classroom teachers). Yes ___ No ___

I give permission for this student to self-administer medication if the school nurse determines it safe and appropriate. Yes ___ No ___

I give permission for the school nurse to share information with the prescriber about my child and this medication. Yes ___ No ___

Parent/Guardian Signature _____ **Date** _____

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