GRAND FORKS PUBLIC SCHOOLS
Record of Medication

Student's Name:	Grade:

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

To be completed by a physician:

In the absence of trained medical personnel, I hereby authorize any person or persons indicated by the principal to administer the following medications at school:

Medication	Dose	Time	Directions

Physician Signature: Date:	Parent 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 ☐ EpiPen ☐ Other _____

Physician Signature: Date:	Parent Signature: Date:

DAILY RECORD OF ADMINISTRATION

Medication	Dose	Date/Time Given	Given By

KEEP THIS FORM WITH THE MEDICATION