MSSD Medication Authorization Form

This form serves as verification of the medications your student is taking, as well as authorization for the medical staff at Student Health Services to administer the medications, as ordered by your student's primary care provider (MD, DO, NP or PA). Please fill out and submit this form with the other required medical documentation before your student arrives at MSSD.

Student's Printed Name ________________________ Date of Birth ________________

Parents/Guardians, please check (✔) the following option that applies to your student and sign:

☐ My student does **NOT** take any prescription(s) or over the counter medication(s)
☐ My student **ONLY** takes over the counter medication(s), vitamin(s) or supplement(s)
☐ My student takes prescription medication(s), **with or without** additional over the counter medication(s)

Parents/Guardian Name ________________ Parent/Guardian Signature ________________ Date ________

If your student **does not take any medications**, you only need to fill out page 1.

If your student only takes **over the counter (OTC) medications (vitamins, supplements, sleep aids, ect)**, fill out both pages but only sign page 1.

If your student is taking **any prescribed medications**, please fill out both pages and have their primary care provider sign and date page 2, listing their pertinent diagnosis as it relates to their medication.

If there are any new medications, dose or frequency changes, or your student stops taking medication(s), you will need to fill out a new form and submit it to Student Health Services.

MODEL SECONDARY SCHOOL FOR THE DEAF
800 Florida Avenue, NE • Washington, DC 20002-3695
(202) 651-5031 (voice) • (202) 250-2152 (videophone) • (202) 651-5109 (fax) • www.gallaudet.edu

MSSD Medication Authorization Form

____ __________________________
Student's Printed Name Date of Birth

NAME OF MEDICINE	DOSE/FREQUENCY	SIDE EFFECTS

Diagnosis:____

____

Physician's Name Phone Number Fax Number

Physician's Address

Physician's Signature:____ Date:__________________

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