South Elementary
Fax #: 616-997-3114

ADMINISTRATION OF MEDICATION CONSENT FORM

Medications (both prescription and over the counter) may be administered at school by school personnel when necessary for school attendance. This completed form along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

As a parent, I understand my responsibilities are:

1. *To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy. (Parents may request that the pharmacist dispense two bottles of medication, one for home and one for school)*
2. *To provide the school with the written doctor's instructions for medication administration during school hours*
3. *To inform the school of any medication and/or medical changes*

Medication means: "any prescription or over the countenr medication. This includes, but is not limited to: vitamins and food supplements; eye, ear and nose drops; inhalants; medicated ointments or lotions; aspirins; cough drops; antacids."

Student: ______________________ Birthdate: __________ School Year: __________

Parent/Guardian Name: ______________________ Phone Number: __________

Doctor's Name: ______________________ Dr. Phone Number: __________

Doctor's Address: ______________________

I, ______________________ (Name), ______________________ (Relationship) of

______________________, do hereby request that the building administrator or his/her designee, administer the (prescribed) medication listed below or procedure (listed below) as directed.

This also authorizes an exchange of information, as necessary, between the school and my child's health care provider.

Signature of Parent/Guardian: ______________________ Date: __________

Signature of Student if Adult: ______________________

To be completed by the Physician:

Reason / Condition for medication: ______________________

Name of Medication: ______________________

Form of Medication: ☐ tablet/capsule ☐ liquid ☐ inhaler ☐ injection ☐ nebulizer ☐ Other

Dosage: ______________________ Time *during* school __________

Restrictions / and or side effects: ☐ none anticipated ☐ Yes

Please describe ______________________

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Storage requirements: ☐ none ☐ refrigerate ☐ other

This student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes

**Additional information: ☐ attached ☐ on back of form

______________________ Physician's name printed ______________________ Physician's signature

Physicians's address: ______________________

Phone: __________ Fax: __________ Date: __________

A copy of this form will be kept in the student's CA-60 and nurse's office and will be renewed annually or whenever the prescription changes within the current school year.