Teacher _____ School Yr

Grade _____

HUDSONVILLE PUBLIC SCHOOLS

Authorization for Medication/Parental Consent
OVER THE COUNTER MEDICATIONS

I, the parent/guardian of _____ birth date of _____ request that my child be administered _____ at school.
(medication name)

Please administer the above named medication:

at these times: _____

in the following dosage: _____

for the treatment of: _____

Due to the fact that this medication requires a dosage to be administered during school hours, I hereby authorize the school administration or designee to dispense the medication according to the above directions.

As a parent, I understand my responsibilities are:

1. To provide the school with an **unopened bottle** with a current expiration date for the safety of above mentioned student and protection of school personnel. **No opened bottles, baggies, or envelopes will be accepted as a recommendation from the Ottawa County Health Department.**
2. To inform the school of any medical changes.
3. To provide the school with this signed PARENTAL CONSENT form annually or upon any changes.

As a school staff, we are responsible for:

1. Administering the correct dosage at the correct time according to the above instructions.
2. Releasing medical information on your son/daughter only with your written approval, except in the case of an emergency.
3. Keeping records of all dispensing of the above listed medication.
4. To inform you, as parents, of any relevant concerns or noticeable side effects.

I hereby give my consent for administration of the above specified medication by authorized school personnel. In giving consent, I fully realize that I can withdraw, in writing, this consent at any future date.

Signed: _____ Date: _____
(Parent/Guardian)