

# 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 the original **UNOPENED** labeled container with current expiration date (NO OPENED BOTTLES, BAGGIES OR ENVELOPES WILL BE ACCEPTED).
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)