______MEDICATION IN OFFICE

______MEDICATION WITH STUDENT

HUDSONVILLE PUBLIC SCHOOLS

Authorization for Medication/Parental Consent
Prescription Medications

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

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 labeled container with a current date (no baggies, opened containers)
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 doctor's 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)

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Physician's Instructions for Prescription Medicine

To be completed by the Physician in case of prescription medication:

Student's Name____________________________________ **Date of Birth**________________
Name of Medication________________________________ **Dosage**_____________________
Directions for Storage______________________________ **Time of Administration**_________
Expected Duration of Treatment______________________ **Diagnosis**____________________
Possible Side Effects_______________________________ **Other Instructions**____________

○ **I have instructed this patient on administration of above said prescription. If this is for treatment of asthma, I have attached a peak flow range.**

____ **Date**________________________
Physician's Signature