Student Name:_____ School Year:_____
Grade:_____

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 UNOPENED 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 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)

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_____

_____ Date_____
Physician's Signature

Please fax to Georgetown Elementary office at 616-797-9929