Hudsonville Public Schools

Authorization for Medication/Parental Consent (excluding self-adminstered medications)

FOR SCHOOL USE
Date Rec'd: _____
By Whom: _____

I, the parent/guardian of _____ birth date of _____

request that my child be administered (medication) _____ at school.

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 administrator or designee to dispense the medication according to the above directions or per the physician's prescription in the case of prescription medicine.

As a parent, I understand my responsibilities are:

1. To provide the school with the original labeled container with a current date.
2. To provide the school with the written doctor's instructions for prescription medication.
3. To inform the school of any medical changes.
4. 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 prescription.
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.
5. To dispose of any unused medication at the end of the time interval or have it picked up by the parent/guardian.

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 MEDICATIONS

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

Student's Name: _____

Name of Medication: _____

Dosage: _____

Directions for Storage: _____

Time of Administration: _____

Expected Duration of Treatment: _____

Possible Side Effects: _____

Other instructions: _____

Diagnosis: _____

_____ _____
Doctor's Signature Date

This form is to be kept in the student's CA-60 school records. This form is to be reviewed annually or whenever the prescription changes during the current school year.