AUTHORIZATION TO ADMINISTER MEDICATION TO STUDENTS
PRESCRIPTION AND OVER THE COUNTER

Whenever possible, medication should be given to students while at home and every effort should be made to avoid having students take medication during school hours. When that is not possible, medication will be administered at school within the Thornapple Kellogg School Board guidelines.

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that ____ in grade __________
(Student Name)

☐ receive the prescribed medication listed below from the designated school personnel;
☐ self-administer the prescribed medication as permitted by law.

Name of medication: ____
Dosage of medication: __________________________Time to be given: ____________________

The medication is to be provided by me and dispensed and/or administered according to Board of Education Policy and administrative regulations. I will assume responsibility for safe delivery of the medication to the school, and will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from the authorization.

Parent/Guardian Signature____________________________________ Date ______________

Name/number for emergency notification ____

TO BE COMPLETED BY PHYSICIAN FOR PRESCRIPTION MEDICATION:

I request that my patient _______________________________________ receive medication in accordance with the conditions described below:

Name of medication: ____

Prescribed dosage and means of administration: _______________________________________

Time to be taken during school hours: ____

Date medication is to begin: __________________ Date medication is to cease: ______________

Possible side effects and adverse reactions: ____

Other recommendations: ____

Physician's Signature _______________________________________ Date ______________

Address: ____

Phone Number: _____________________________

A copy of this form is to be kept with the medication.