Permission for Medication

School Name: _____
Cedar Springs Public Schools
204 E. Muskegon St., Cedar Springs, MI 49319

Excellence & Innovation

Date form received by the school: _____

Student: _____Date of Birth _____Age _____

Grade: _____ Teacher/Classroom: _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of Medication: _____

Reason for Medication: _____

Form of medication/treatment: _____

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other_____

Instructions (Schedule and dose to be given at school): _____

Physician's Printed Name: _____ Address _____Phone _____

Physician's Signature: _____ Date _____

ELEMENTARY STUDENTS (Grades K – 6) MAY NOT SELF-CARRY OR SELF-ADMINISTER MEDICATION IN ACCORDANCE WITH OUR DISTRICT POLICY. (With the exception of rescue inhalers upon written physician approval.)

This Student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes-Unsupervised ☐ Yes-Supervised May this student carry this medication ☐ No ☐ Yes

I give my permission for my child _____be allowed to self-administer at school the above medication in accordance with our School Policy. **Authorization includes permission for school personnel and health care provider to contact each other if needed. Medication and Treatment information is kept confidential but it may be shared with appropriate staff for emergency care**.

Parent/Guardian Signature _____ Relationship _____Date _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child _____ to receive the above medication at school according to standard school policy. (We require **parent/guardians** to bring the medication in its **original** container.) **Authorization includes permission for school personnel and health care provider to contact each other if needed. Medication and Treatment information is kept confidential but it may be shared with appropriate staff for emergency care.**

Parent/Guardian Signature _____ Relationship _____Date _____