FOR SCHOOL USE ONLY
Date Rec'd________
By Whom:________
Med Expires:________

Authorization for Medication
Parental and Physician Consent (excluding self-administered medications)

I, the parent/guardian of:____birth date of:_______________
Request that my child be administered (medication)____at school.

Dosage:__________________________ Time/Frequency:___________________________________

As needed for the following symptoms:____

As a parent/guardian, I understand my responsibilities are:

1. To provide the first dose to my child of any **new** medication. Exceptions are Epi-Pen in case of emergency only.
2. To provide the school with the original labeled container with a current date.
3. To provide the school with the written doctor's instruction (see below) or original prescription bottle. Prescription bottles must specify dose and time of administration for staff to accept.
4. To provide physicians instructions/signature for any over the counter medication.
5. To transport any medication to the school. Students may not transport medication.
6. To prove the school with this signed PARENTAL CONSENT FORM at the beginning of each school year or upon any changes.
7. To pick up, or have otherwise disposed of, any unused medication at the end of the time interval.

As a school staff, we are responsible for:

1. Administering the correct dosage at the correct time according to the prescription/physician instructions.
2. Releasing medical information on your son/daughter only with your written approval, except in the case of emergency.
3. Keeping records of all dispensing of the above listed medication.
4. Informing you, as parent/guardian, of any relevant concerns or noticeable side effects.
5. Disposing of any unused medication at the end of the scheduled time if not picked up by parent/guardian.

I hereby give my consent for administration of the above specified medication by authorized school personnel according to the pharmacy labeled container or per physician's instructions below. This also authorizes an exchange of information, as necessary, between the school and my child's health care provider. A copy of this form will be kept in my child's CA-60 file.

Parent/Guardian Signature:______________________________________ Date:___________________________
Home phone:____________________________ Work Phone:____________________________________
School Year:____________________________ Teacher/Grade:_________________________________

Check Appropriate School:

___ Bauerwood Elementary-Phone (616) 457-1408- Fax (616) 457-8491
____ Bursley Elementary-Phone (616) 457-2200-Fax (616) 457-8489
____ ECC-Phone (616) 777-6534-Fax (616) 457-8492
____ El Puente-Phone (616) 777-6531-Fax (616) 457-8676
____ JIA Elementary-Phone (616) 457-8477-Fax (616) 457-8393
____ Pinewood Elementary -Phone (616)457-1407-Fax (616) 457-8490
____ Rosewood Elementary-Phone (616)669-0011-Fax (616)669-5980
____Sandy Hill Elementary-Phone (616) 457-1404-Fax (616) 457-8493
____Jenison Int'l Academy-Phone (616) 457-8477- Fax (616) 457-8393
____ Jenison Junior High (616) 457-1402- Fax (616) 457-8090
____Jenison Senior High/Wildcat Prep- Phone (616) 457-3400- Fax (616) 457-4070

PHYSICIAN'S INSTRUCTIONS FOR NON-PRESCRIPTION MEDICATIONS

Student Name:____________________________ Name of Medication:_________________________________
Dosage/Route:____________________________ Time/Frequency:____________________________________
Beginning and Ending Date:___________________
Possible Side Effects:____
Diagnosis:____

Physician's Name (printed):______________________________ Date:___________________________

Physician's Signature:___________________________________ Phone:__________________________