

Jenison Public Secondary Schools

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

FOR SCHOOL USE

Date Rec'd: _____

By Whom: _____

Med Expires: _____

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 school with the original labeled container with a current date.
2. To provide the school with written doctor's instructions/signature for non-prescription medication administered during school hours.
3. To inform the school immediately of any medical changes.
4. To provide the school with this signed PARENTAL CONSENT FORM at the beginning of each school year or upon any changes.
5. 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 an 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 time interval if not picked up by the 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 the 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: _____

Student Signature (if over 18 years of age): _____

Home Phone: _____ Work Phone: _____

School Year: _____ Grade: _____

Check Appropriate School:

- | | |
|---|--|
| <input type="checkbox"/> Senior High School – Phone (616) 457-3400 – FAX (616) 457-4070 | <input type="checkbox"/> Jenison Int'l Academy – Phone (616) 457-8477 – FAX (616) 457-8393 |
| <input type="checkbox"/> Junior High School – Phone (616) 457-1402 – FAX (616) 457-8090 | |

PHYSICIAN'S INSTRUCTIONS FOR NON-PRESCRIPTION MEDICATIONS

Student's 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: _____