

Medication/Treatment Consent Form

Student Name: _____ Date of Birth: _____

Diagnosis: _____ School Year: _____

CONSENT FOR ADMINISTRATION OF HEALTH TREATMENT AND/OR MEDICATION AT SCHOOL

- Parents are urged to provide health treatments and give medications at home and on a schedule other than school hours if possible. If it is necessary that treatment and/or medication is to be provided during school hours these regulations must be followed. Please note: "Medication" refers to any prescription, non-prescription, homeopathic, herbal, vitamin or mineral preparation.
- Health treatments and medications **must** be prescribed in writing by a physician or other licensed healthcare provider and must be renewed at least annually. Providers complete the table below, indicate self carry option, and sign at the bottom. Fax of written instructions may be sent by the medical provider to 517-647-2975.
- All medication, prescription and non-prescription, must be brought to school in the original pharmacy container with a current label showing the name of the student, medication, strength, dosage and time to be given. Only the parent/guardian or other responsible adult may deliver the medication to school.
- Health treatment supplies will be provided for school use for each student by the parent/guardian as needed.
- Parent/guardian must sign and return this form for staff to administer treatments and medications at school as directed by the licensed healthcare provider below. **Parent and licensed healthcare provider must sign below.**

Medication	Strength	Dosage/ Route	Time/Frequency	As Needed Indications

Recommendations, Special Considerations, Side Effects, Precautions, Allergies

Healthcare providers: Check this box to indicate that the student may be evaluated to self carry medication

The following signatures serve as written authorization for permission to administer health treatment and/or medication as directed at school. Authorization includes permission for school personnel and healthcare 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.

Physician Signature _____ Phone _____ Date _____

Parent Signature _____ Phone _____ Date _____