ZEELAND CHRISTIAN SCHOOL

ADMINISTRATION OF MEDICATION CONSENT FORM

Medications (both prescription and over the counter) may be administered at school by school personnel when necessary for school attendance. This completed form along with the medication and/or special equipment items are to be brought to the school by the parent/guardian. Medication will not be administered at school until these criteria are met.

As a parent, I understand my responsibilities are to:

1. ***Provide the school with a supply of medication in the original container appropriately labeled by the pharmacy. (Parents may request that the pharmacist dispense two bottles of medication, one for home and one for school.)***
2. ***Provide the school with the written doctor's instructions for medication administration during school hours.***
3. ***Inform the school of any medication and/or medical changes and provide updated instructions related to changes.***

Medication means: "*Medication" shall include all medicines, including those prescribed by a physician and any non-prescribed (over-the-counter) drugs, preparations, and/or remedies. Medications (excluding emergency inhalers or epinephrine pens) shall be kept in locked storage in the school office or designated space*

I, _____, _____

Parent/Guardian Name — Relationship to Student (Mother/Father/Guardian)

of _____, _____/_____/_____

Student Name — *Student Birthdate*

do hereby request that the building administrator or his/her designee, administer the (prescribed) medication according to the guidelines, both listed below:

Form of Medication: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other_____

Dosage: _____ Time During School Day:_____

Restrictions/Side Effects: ☐ None Anticipated ☐ Yes/Please Describe _____

Board policy on student self-admininstration of medication is limited to epinephrine and asthma inhalers. Bi-Laws & Policies are available for review.

This student is capable and responsible for self-administering board-approved emergency medication? ☐ Yes ☐ No

Additional Information: ☐ Attached ☐ Written on reverse side.

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 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 — Today's Date — Parent/Guardian Phone Number

_____/___/_____

Doctor (MD, DC, PA, Nurse) Signature — Today's Date — Doctor's Name PRINT

_____-_____-_____-_____-_____

Doctor's Address — Doctor's Phone — Doctor's Fax