ZEELAND CHRISTIAN SCHOOL

Medications 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.

TO BE COMPLETED BY PARENT / GUARDIAN

Student's Photo

I, the parent/guardian of _____ DOB _____ request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I give permission to share, if necessary, this information with school personnel who may be involved with the welfare of my child. I fully realize I can withdraw my request/consent in writing at any future date.

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

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours and that medication will not be administered until signed doctors instructions are at school.
3. To inform the school of any medical changes.
4. I will assume responsibility for safe delivery of the medication to school.
5. To provide the school with this signed consent form annually and when changes in medication occur.
6. I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damage or injury resulting directly or indirectly from this authorization.

TO BE COMPLETED BY PARENT / GUARDIAN

My child has been diagnosed with migraine headaches. The goal is to keep him/her in school and able to concentrate/participate in school activities.

Triggers (parent/guardian to complete)

- ☐ Missing a meal
- ☐ Weather changes
- ☐ Exertion
- ☐ Sleep (oversleeping/lack of sleep)
- ☐ Stress
- ☐ Various odors
- ☐ Lights/strobe or flashing
- ☐ Physical illness
- ☐ Loud/continuous noises
- ☐ Certain foods/drink (spcificy):_____
  _____
- ☐ Other:_____
  _____

Migraine Symptoms:

_____
_____
_____

Treatment should begin with the first symptoms for medication to be effective. Student should be allowed to rest for at least 20 minutes after medication.

Notify Parent:

- ☐ At onset
- ☐ If no relief in 1 hour
- ☐ Other _____

MEDICATIONS TO BE GIVEN AT SCHOOL:

Name of Medication	Dosage	When To Use

MEDICATIONS GIVEN AT HOME:

Name of Medication	Dosage

NON-PHARMACEUTICAL TREATMENTS:

- ☐ Water
- ☐ Food
- ☐ Rest
- ☐ Other:_____

Signature of Parent/Guardian: _____

Relationship: _____ Date: _____

Emergency Contact Phone #_____

TO BE COMPLETED BY PHYSICIAN

Please review parent provided information, sign and return to parent.

_____ _____

Physician's Name Printed Physician's Signature

_____

Physician's Address

Phone:_____ Fax:_____ Date:_____