

**AUTHORIZATION TO ADMINISTER MEDICATION TO STUDENTS
PRESCRIPTION AND OVER THE COUNTER**

Whenever possible, medication should be given to students while at home and every effort should be made to avoid having students take medication during school hours. When that is not possible, medication will be administered at school within the Thornapple Kellogg School Board guidelines.

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that _____ in grade _____
(Student Name)

- receive the prescribed medication listed below from the designated school personnel;
- self-administer the prescribed medication as permitted by law.

Name of medication: _____
Dosage of medication: _____ Time to be given: _____

The medication is to be provided by me and dispensed and/or administered according to Board of Education Policy and administrative regulations. I will assume responsibility for safe delivery of the medication to the school, and will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

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 damages or injury resulting directly or indirectly from the authorization.

Parent/Guardian Signature _____ **Date** _____

Name/number for emergency notification _____

TO BE COMPLETED BY PHYSICIAN FOR PRESCRIPTION MEDICATION:

I request that my patient _____ receive medication in accordance with the conditions described below:

Name of medication: _____

Prescribed dosage and means of administration: _____

Time to be taken during school hours: _____

Date medication is to begin: _____ Date medication is to cease: _____

Possible side effects and adverse reactions: _____

Other recommendations: _____

Physician's Signature _____ **Date** _____

Address: _____

Phone Number: _____

A copy of this form is to be kept with the medication.