FORM 5330 F1a

Grand Haven Area Public Schools

District Nurse ▪ Abby Lorenz RN, BSN
1415 Beechtree ▪ Grand Haven, MI 49417
Ph: 616-850-5071 Fax: 616-850-5088 ▪ lorenza@ghaps.org

Grand Haven Area Public Schools

Authorization for Self-Administration/Self-Carry of Nonprescribed Medication

(Grades 9th-12th only)

Student: _____ Birthdate: _____ Effective School Year: _____

School: _____ Teacher: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____Relationship: _____ Phone: _____

PARENT/GUARDIAN AUTHORIZATION:

I, _____, the _____ of _____ request
Parent/Guardian Name — Relationship — Student Name

that my child ☐ **self-administer and/or** ☐ **self-carry the over-the-counter** medication listed below. I understand self-carry/ self-administration privileges may be withdrawn if my child exhibits behavior, which indicates lack of responsibility toward self or others in regards to his or her medication.

As a parent, I understand my responsibilities are:

1. To ensure this medication is safe for my child (ex. drug interactions, allergies, etc).
2. To instruct my child on the proper use of the medication.
3. To ensure the medication is kept in its original container.
4. To update this form annually and with any change to the medication during the current school year.

Parent/Guardian Signature: _____ Date: _____

MEDICATION INSTRUCTIONS:

Reason/Condition for Medication (Optional): _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ Start/Stop Date: _____

If *AS NEEDED,* frequency and with which symptoms: _____

_____

Relevant side effects: □ None expected □ Yes, specify: _____

A COPY OF THIS FORM WILL BE KEPT IN THE STUDENT'S CA-60 AND NURSE'S OFFICE AND WILL BE RENEWED ANNUALLY OR WHENEVER THE MEDICATION CHANGES WITHIN THE CURRENT SCHOOL YEAR.