Grand Haven
Area Public Schools
1415 S. Beechtree Street Grand Haven, MI 49417

FORM 5330 F1

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Medication Request and Authorization Form

Policy 5330 ""Medication" shall include all medicines including those prescribed by a physician and any non prescribed (over-the-counter) drugs, preparations, and/or remedies" which are administered by the building administrator or his/her designee.

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 the building administrator, or his/her designee, administer the medication listed below as directed. I give my consent for the exchange of information, as necessary, between the school and my child's health care provider. I fully understand I can withdraw my request/consent in writing at any future date. I understand medication must be picked up by the end of the school year or it will be discarded.

As a parent, I understand my responsibilities are:

1. To provide the school with physician's written instructions and signature before the administration of medication at school.
2. To provide the school with an adequate supply of the medication in the original pharmacy labeled container.
3. Non Prescriptions must be in original packaging labeled with students name and date of birth. Parent/guardian must bring the medication to the office.
4. To renew this form annually or when a change in this medication occurs.

Parent/Guardian Signature: _____ Date: _____

TO BE FILLED OUT BY PHYSICIAN:

Reason/Condition for Medication (Optional): _____
Medication Name: _____ Dose: _____ Route: _____
Time/frequency of administration: _____ Start/Stop Date: _____
If *AS NEEDED* frequency and symptoms: _____
Relevant side effects: □ None expected □ Yes, specify: _____
Storage requirements: □ none □ refrigerate □ other: _____
Other special considerations (i.e. take with food) _____

Physician's Name: _____ (Printed)
Physician's Signature: _____
Address: _____
Telephone: _____ FAX: _____

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