Form 5330 F1

Grand Haven Area Public Schools
Medication Request and Authorization Form

Policy 5330 “Medication” shall include all medicines including those prescribed by a physician and any nonprescribed (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 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. Nonprescriptions must be in original packaging labeled with students name and date of birth. Parent/guardian must bring the medication to the office.
3. 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 CA-60 AND NURSE’S OFFICE AND WILL BE RENEWED ANNUALLY OR WHENEVER THE MEDICATION CHANGES WITHIN THE CURRENT SCHOOL YEAR.