Permission for Medication

Name of School: ___________________________________
Cedar Springs Public Schools (CSPS)
204 E. Muskegon St., Cedar Springs, MI 49319

STUDENT: ____Today's Date: ____________ Academic Year: _________

Grade: __________ Teacher (K-5):____________________________Student's Date of Birth: ____________ Age: _____

☐ Form Reviewed by District Nurse/Authorized CSPS Staff ____________________________

Prescription Medication. **This section MUST be completed & signed by the PHYSICIAN or AUTHORIZED PRESCRIBER**

Name of Medication:_________________________________Reason for Use: ____________________________________

Form of Medication/Treatment: ☐Tablet/Capsule ☐Liquid ☐ Inhaler ☐ Injection ☐Nebulizer ☐Ointment ☐other ______________

Instructions (Schedule and dose to be given at school):____

*Student is capable and responsible for **self-administering** the above prescription medication ☐ Yes - Unsupervised ☐ Yes - Supervised ☐ No

Physician's Printed Name: ____**Phone** ___________________

Physician's Signature: ____**Date**___________________

I give permission for my child _________________________to receive the above medication at school in accordance with CSPS school medication administration policy. (CSPS requires parent/guardian deliver medication to school and medication ***is kept in the original container****).*

Parent/Guardian Signature_________________________________**Relationship** ____________ **Date**______________

Over the Counter Medication (OTC) & Treatments. **This section MUST be completed & signed by PARENT or GUARDIAN**

Name of Medication: _______________________________Reason for Use:_____________________________________

Form of Medication/Treatment: ☐Tablet/Capsule ☐Liquid ☐ Inhaler ☐ Injection ☐Nebulizer ☐Ointment ☐other_____________

Instructions (schedule and dose to be given at school)____

I give permission for my child ____________________________ to receive the above medication at school in accordance with CSPS school Medication Administration policy. (CSPS requires ***parent/guardian*** *delivers medication to school and that it is kept in the* ***original container****).*

Authorization also includes permission for school personnel and/or health care provider to contact each other as needed. Medication and Treatment information is kept confidential but may be shared with appropriate school staff, administration, health care personnel, or emergency services.

Parent/Guardian Signature ______________________________ **Relationship** ______________**Date** _______________

SELF ADMINISTER/SELF-CARRY. **THIS SECTION IS TO BE COMPLETED BY PARENT/GUARDIAN**

*This Student is capable and responsible for **self-administering** the above medication ☐ Yes - Unsupervised ☐ Yes - Supervised ☐ No

*Students in grades 6-12, may **self-carry** a **single dose** of their medication ONLY with signed permission and ONLY when in original container.

I give permission for my child ___________________to ☐ **self-administer** ☐ **self-carry** the above medication at school in accordance with CSPS School Self-Administration Policy. **Authorization also includes permission for school personnel and health care providers to contact each other as needed. Medication and Treatment information is kept confidential but it may be shared with appropriate school staff, administration, health care personnel, or emergency services.**

Parent/Guardian Signature __________________________________**Relationship** _________________**Date**____________