CEDAR SPRINGS PUBLIC SCHOOLS
Permission for Medication

Student Name: _____ Date of Birth: _____
Grade: _____ Teacher (K-5): _____ Date: _____
☐Form Reviewed by District Nurse/Authorized CSPS Staff

Prescription Medication
This section MUST be completed & signed by the PHYSICIAN or AUTHORIZED PRESCRIBER
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).
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: _____ Date: _____
Relationship: _____

OVER THE COUNTER MEDICATION (OTC) & TREATMENTS
This section MUST be completed & signed by PARENT or GUARDIAN
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
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).
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: _____ Date: _____
Relationship: _____

SELF ADMINISTER/SELF-CARRY *This section must be completed by a parent/guardian*
This student is capable and responsible for **self-administering** the above prescription 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 the 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 may be shared with appropriate school staff, administration, health care personnel, or emergency services.
Parent/Guardian Signature: _____ Date: _____
Relationship: _____