Hudsonville Public Schools

Medication Administration Authorization Form

2023-2024

This form must be completed for Hudsonville Public Schools to administer required medication in the school setting

- A new medication administration form must be completed for each medication, and each time there is a change in dosage/instructions
- Physician/authorized prescriber signature is required for prescription medication
- Prescription medication must be in the original container with a pharmacy label
- Non-prescription medication must be in the original container with the factory label and not expire during the school year
- All medication must be delivered to the office by a parent/guardian - medication *cannot* be sent to school with a student

Name of Student: _____ DOB:_____ Grade: _____

Name of Medication: _____ Diagnosis: _____

Medication Dosage: _____ Medication Administration Time(s): _____

Medication Route: _____ Tablet/Capsule _____ Liquid _____ Inhaler _____ Nebulizer _____ Injection _____ Other

Special Instructions/Possible Side Effects: _____

TO BE COMPLETED BY PARENT/GUARDIAN (Information in this section must be completed for ALL medication)

- My signature below indicates my permission to administer the above medication to my child and authorization for school health personnel and health care provider to contact each other if necessary.

Parent/Guardian Printed Name: _____ Preferred Contact Number: _____

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY THE PHYSICIAN/AUTHORIZED PRESCRIBER (Must be completed for ALL prescription medication)

- If the medication is for Asthma/Allergy/Diabetes/Seizures please also include the medical management plan.
- My signature below indicates the above medication information is correct as prescribed.

Prescriber Name/Title: _____ Office Phone: _____

Prescriber Signature: _____ Date: _____

Address: _____ Office Fax: _____

SELF-CARRY/SELF-ADMINISTRATION AUTHORIZATION (PRESCRIPTION EMERGENCY MEDICATIONS)

- No prescription medication is to be kept with the student *UNLESS* both physician/authorized prescriber and parent provide authorization for the following emergency medications only - Asthma Inhalers, Epi-Pen, or prescribed emergency medication.

Prescriber's authorization for self-carry/self-administration of above medication: _____ Date: _____

Parent/guardian authorization for self-carry/self-administration of above medication: _____ Date: _____

SELF-CARRY/SELF-ADMINISTRATION AUTHORIZATION (NON-PRESCRIPTION/OVER-THE-COUNTER MEDICATIONS)

- Non-prescription/over-the-counter medication may be self-carried/self-administered if the student is in grades 6-12 and parent provides authorization.

Parent/guardian authorization for self-carry/self-administration of above medication: _____ Date: _____