Allendale Public Schools
District Nursing Office | 10690 Learning Lane, Allendale, MI 49401 | Office: (616) 892-3939 | Fax: (616) 895-9191

Permission Form for Non-Prescription (OTC) Medication

This form must be completed fully for APS staff to administer the specified medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication. Medication policy requirements include, but not limited to, the following:

- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the school.
- The school RN will call the parent/guardian and/or prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Student Demographics

This form is valid for the ______-______ school year (including summer session). Date: ___________ School: ____________________

Name of Student: ____ DOB: ________________ Teacher/Grade: ___________________

Medication Information

Condition for which medication is being administered: ____

Name of medication: ____ Dose: ___________________ Route: _________________

Time/frequency of medication (at school): ___________________________________ If as needed, frequency: ____________________

Medication shall be administered from (date): __________/_____________/___________ to __________/_____________/__________

If as needed, for what symptoms: ____

Relevant side effects: ☐ None expected ☐ Specify: ____

Form of medication: ☐ Tablet/capsule ☐ Liquid ☐ Topical ☐ Other: ___________ Taken the medication before: ☐ Yes ☐ No

Special Storage Requirements: ☐ None ☐ Specify: ____

Special Instructions/Precautions: ☐ None ☐ Specify: ____

Physician's Name: ____ Office Phone: _______________________

Medication Parent/Guardian Authorization

I/We request designated school personnel to administer the medication as written above. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA with proper medical release of information documentation.

Parent/Guardian Signature: ____ Date: ___________________

Phone Number: _____________________________ ☐ Home ☐ Cell ☐ Work