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

Permission Form for Prescribed 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:

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- 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 Physician Authorization

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 ☐ Inhaler ☐Injection ☐Nebulizer ☐ Topical ☐ Other: _____

Special Storage Requirements: ☐ None ☐ Specify: _____

This student is both capable and responsible for self-administering this medication: ☐ Yes (Unsupervised) ☐ Yes (Supervised) ☐ No

This student may carry this medication: ☐ Yes ☐ No Other Considerations: _____

Have you provided additional information as an attachment (i.e. asthma/seizure/diabetes/allergy action plans, etc.): ☐ Yes ☐ No

Physician's Name/Title: _____ Office Phone: _____

Office Address: _____ Fax Number: _____

Physician Signature: _____ Date: _____

Medication Parent/Guardian Authorization

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. 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