MEDICATION/TREATMENT
CONSENT FORM FOR SELF-ADMINISTRATION

GRPS my choice
Grand Rapids Public Schools
WWW.GRPS.ORG

Student Name _____ Birth Date _____ School Year _____

Diagnosis/Condition _____

CONSENT FOR ADMINISTRATION OF HEALTH TREATMENT AND/OR MEDICATION AT SCHOOL

- Parents are urged to provide health treatments and give medication at home and on a schedule other than school hours if possible. If it is necessary that treatments and/or medication be provided during school hours, these regulations must be followed. *Please Note: "Medication" refers to any prescription, non-prescription, homeopathic, herbal, vitamin, or mineral preparation.*
- Self-administration provisions are for high school students only with the exception of inhalers, epipens and glucagon.
- Health treatments and medications must be prescribed in writing by a physician or other licensed health care provider and must be renewed at least annually. Providers complete Part 1 below and must sign form—Part 2 and fax written instructions to school.
- All medication, prescription and non-prescription, must be brought to school in the original pharmacy container only with a current label showing the name of the student, medication, strength, dosage, and time(s) to be given. Metered dose inhalers must have a label attached to the container.
- Health treatment supplies will be provided for school use for each student by parent/guardian as needed.
- Parent/guardian written permission is required to administer treatments and medications at school as directed by physician/licensed health care provider, including permission to contact provider as necessary. Parent must sign below—Part 2.
- Any misuse of medication by a student, including selling or giving away the medication, that violates Grand Rapids Public Schools policies will result in revocation of self-administration privileges and may result in a referral to law enforcement officials. Please see the student handbook for Grand Rapids Public Schools policies regarding medication at school.

PART I: PHYSICIAN/HEALTH CARE PROVIDER INSTRUCTIONS

TREATMENT/MEDICATION	STRENGTH	DOSAGE/ROUTE	TIME(S)/FREQUENCY	
			Home	School

Recommendations, Special Considerations, Side Effects, Precautions, Allergies: _____

PART 2: AUTHORIZATION SIGNATURES

The following signatures serve as written authorization for permission for student to self-administer health treatment and/or medication as directed at school. Authorization includes permission for school personnel and health care provider to contact each other if needed. Medication and Treatment information is kept confidential but it may be shared with appropriate staff for emergency care. *Please Note: School personnel will not supervise the medication administration or have responsibility in the process. Parent will be notified of any observed violation of the above guidelines.*

Physician/Provider:
Print Name _____ Signature _____
Date _____ Phone _____ Fax _____

Parent/Guardian:
Print Name _____ Signature _____
Date _____ Phone _____ Fax _____

Student:
Print Name _____ Signature _____
Date _____ Phone _____ Fax _____