



MONTCALM AREA MEDICATION/TREATMENT CONSENT
 INTERMEDIATE SCHOOL DISTRICT

Student Name:

Birth Date:

School Yr:

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.
- 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 with a current label showing the name of the student, medication, strength, dosage, and time(s) to be given. Only the parent/guardian or other responsible adult or the pharmacy may deliver the medicine to school. Students are not allowed to bring their own medication to school.
- 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.

PART 1 - PHYSICIAN/HEALTH CARE PROVIDER INSTRUCTIONS:

Treatment/Medication	Strength	Dosage/Route	Times /Frequency	
			Home	School

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

PART 2 - AUTHORIZATION SIGNATURES

The following signatures serve as written authorization for permission to 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.

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