

ADMINISTRATION OF MEDICATION CONSENT FORM for 2025-26

Medications may be administered at school by personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

“Medication” means: prescription, non-prescription and herbal medication, including those taken by mouth, taken by inhaler, which are injectable, applied as drops to eyes or nose, or applied to the skin.

TO BE COMPLETED BY PARENT/GUARDIAN

I, the parent/guardian of _____ date of birth _____ request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child’s health care provider. I fully realize I can withdraw my request/consent in writing at any future date.

As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy. *(Parents may request that the pharmacist dispense two bottles of medication, one for home and one for school)*
2. To provide the school with the written doctor’s instructions for medication administration during school hours.
3. To inform the school of any medical changes.
4. To provide the school with this signed consent form annually and when changes in medication occur.

Signature of _____
Parent/Guardian _____ Relationship _____ Date _____

TO BE COMPLETED BY PHYSICIAN

Reason for Medication/Treatment _____

Name of Medication/Treatment _____

Form of Medication: ___ tablet/capsule ___ liquid ___ inhaler ___ injection
 ___ nebulizer ___ other _____

Dosage _____ Time of Administration _____

Restrictions and/or side effects: _____ None Anticipated _____ Yes (describe) _____

Storage Requirements: _____ None _____ Refrigerate _____ Other _____

Other Instructions: _____

This child has been instructed in the proper way to use his/her medication. It is my professional opinion that this child should be allowed to carry and use this medication by him/herself. _____ No _____ Yes

Physician’s Signature _____ Date _____

Physician’s Name (printed) _____

Address _____

Phone Number _____ FAX Number _____

2025-2026

Hold-Harmless Catheterization Procedure

Permission to allow Jenison Christian School's trained staff to do a Catheter Procedure

I, the parent/guardian of _____ date of birth _____

Give permission for a designated (trained) staff member of Jenison Christian School to assist _____ with her catheter. I understand that the staff member is not a medical specialist or had official medical training to do this procedure. Thus, I will not hold Jenison Christian School or any staff member working with _____ to be held responsible now or any time in the future from problems that may arise from this procedure being done in school.

Parent/guardian signature: _____ Date: _____

I, _____ give permission and authorization for the staff of
Parent/Guardian Name
Jenison Christian School and the staff of _____ to share records
Medical Provider Company Name
and communication for the primary purpose of care for my child _____.
Child's Name

(Parent/Guardian Signature)

(Date)