JENISON CHRISTIAN SCHOOL

Distinctively Academic, Distinctively Christian

ADMINISTRATION OF MEDICATION CONSENT FORM for 2024-25

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 _____

This form is to be kept in the students CA-60 school records.
This form is to be reviewed annually or whenever the prescription changes during the current school year.

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MEDICATION/TREATMENT CONSENT FOR SELF-ADMINISTRATION 2024-25

"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 my child be allowed to self-administer the medication described below. 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 my child with a supply of his/her medication in the original container appropriately labeled by the pharmacy. Metered dose inhalers must have a label attached to the container. *(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 any medication self-administered 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.

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: _____

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 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.

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

This form is to be kept in the students CA-60 school records.
This form is to be reviewed annually or whenever the prescription changes during the current school year.