# Kentwood High Schools
# Medication/Treatment Consent for Self-Administration

Student Name: _____ Birth Date: _____ School Yr: _____

Diagnosis/Condition: _____

**CONSENT FOR SELF ADMINISTRATION OF HEALTH TREATMENT and/or MEDICATION AT SCHOOL**

- Parents/guardians 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 medications 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 to be self-administered must be prescribed in writing by a physician or other licensed health care provider and must be renewed at least annually. Parts 1 and 2 must be completed below, and provider must sign form.
- Provider signature **is** required for a student to self-administer both prescription and over-the-counter medications.
- All prescription medication 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. Over-the-counter medications must be brought to school in the original container, with current label showing the name of the student, and medication name and strength.
- Health treatment supplies will be provided for school use for each student by parent/guardian as needed.
- Parent/guardian written permission is required for student to self-administer any health treatments and/or medications at school, including permission to contact provider as necessary. Parent/guardian must sign below in Part 2.
- Any misuse of medication by a student, including selling or giving away the medication, that violates Kentwood Public Schools policies will result in revocation of self-administration privileges and may result in a referral to law enforcement officials.

**PART 1 – MEDICATION/TREATMENT 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.

| | ***Printed Name*** | ***Signature*** | ***Date*** | ***Phone*** | ***Fax*** |
|---|---|---|---|---|---|
| Physician/Provider | | | | | |
| Parent/Guardian | | | | | |
| Student | | | | | |


**East Kentwood High School**
**616.698.6700 (p)**
**616.698.6080 (f)**

**East Kentwood Freshmen Campus**
**616.698.9292 (p)**
**616.698.0313 (f)**

**Crossroads High School**
**616.261.6166 (p)**
**616.261.6170 (f)**