BYRON CENTER PUBLIC SCHOOLS
Helping Students Build Success Stories

MEDICATION/TREATMENT CONSENT FORM 2023-2024

Building: HS WMS NIS Brown Countryside Marshall ECC

Student Name:______________________ **DOB:**__________ **Grade:**__________

Diagnosis/Condition:______________________________

Parents/Guardians are encouraged 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:

1. A **separate** consent form must be signed for each student receiving medication at school.
2. Parent/Guardian written permission is required to administer all prescription and non-prescription treatments and/or medications at school. Part 2 must be signed.
3. All prescription medications and health treatments must be prescribed in writing by a physician or authorized provider and must be renewed annually. Providers must complete Part 1 below and must sign Part 2.
4. All non-prescription/OTC medications must also be included on this form and do not require a physician signature if dosing per recommended package instructions. Parents must fill in Part 1 and sign Part 2 for all non prescription/OTC medications.
5. All medication, prescription and non-prescription, must be delivered by a parent/guardian and must be in the original container and appropriately labeled with student name and the medication name, strength, dosage, time(s) to be given, and expiration date.
6. Parents/Guardians must pick up all unused medications. No medications will be stored over the summer. Remaining medication will be disposed of properly at the conclusion of the school year.

PART 1: PHYSICIAN/AUTHORIZED PROVIDER INSTRUCTIONS

NAME OF RX or OTC TREATMENT/MEDICATION	STRENGTH	DOSAGE/ROUTE	TIME(S)/FREQUENCY HOME	SCHOOL

Recommendations, Special Instructions and Considerations (including storage and sterility requirements), Side Effects, Precautions, and Allergies:

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PART 2: AUTHORIZATION SIGNATURES

Byron Center School District required that all of the above information be provided before it will administer medication or treatment to the student. 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 providers to contact each other if needed. Medication and Treatment information is kept confidential but it may be shared with appropriate staff for emergency care. I release and agree to hold the Board of Education and it's employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Physician/Authorized Provider: ______________________________

Print Name:__________________ Signature:__________________

Address:______________________________

Phone:______________ Fax:______________ Date:__________

Parent/Guardian:

Print Name:__________________ Signature:__________________

Address:______________________________

Primary Phone:______________ Additional Phone: ______________ Date:__________