BYRON CENTER PUBLIC SCHOOLS
Helping Students Build Success Stories

MEDICATION/TREATMENT CONSENT FORM 2024-2025

This form must be completed for Byron Center Public Schools to administer required medications in a school setting.

Student Name:_____ **DOB:**_____ **Grade:**_____

Building:_____**Diagnosis/Condition:**_____.

- A separate consent form must be completed annually (and with any dosage changes) for each student receiving medication at school.
- Parent/Guardian signature is required to administer all treatments and/or medications at school.
- Physician/Authorized prescriber signature is required for prescription medications/health treatments.
- Prescription medication must be in the original container with a pharmacy label.
- Non-prescription medication must be in the original container with the factory label and not expire during the school year.
- All medication must be delivered by a parent/guardian-medication cannot be sent to school with a student.
- 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.

NAME OF MEDICATION	DOSAGE	ROUTE	ADMINISTRATION TIME

Special Instructions/Possible Side Effects: _____

TO BE COMPLETED BY PARENT/GUARDIAN (Information in this section must be completed for ALL medications)

- My signature below indicates my permission to administer the above medication to my child and authorization for school health personnel and health care providers to contact each other if necessary. I release and agree to hold the Board of Education and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Print Name:_____ Preferred Contact Number:_____

Signature: _____Date:_____

TO BE COMPLETED BY PHYSICIAN/AUTHORIZED PRESCRIBER (Must be completed for ALL prescription medications)

- If the medication is for Asthma/Allergy/Diabetes/Seizures-Please also include the medical management plan
- My signature below indicates the above medication information is correct as prescribed.
- If needed: complete the box below for self-carry emergency medication.

Prescriber Name/Title:_____ Office Phone:_____

Prescriber Signature:_____Date:_____

Address:_____Office Fax:_____

SELF-CARRY/SELF-ADMINISTRATION AUTHORIZATION (Complete for prescription emergency medications ONLY)

- No medication is to be kept with the student UNLESS both physician/authorized prescriber and parent provide authorization for the following emergency medications only-Asthma inhalers, Epinephrine Pen, or prescribed emergency medication.

Prescriber's authorization for self-carry/self-administration of above medication:_____

Parent/guardian authorization for self-carry/self-administration of above medication:_____