MEDICATION/TREATMENT CONSENT FORM 2024-2025



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

udent Name:	DC	DB:	Grade:	
uilding:	_Diagnosis/Condition:			
 Parent/Guardian signature is requ Physician/Authorized prescribers Prescription medication must be Non-prescription medication must All medication must be delivered 	e completed annually (and with any dost irred to administer <u>all</u> treatments and/or signature is required for prescription me in the original container with a pharmate be in the original container with the faby a parent/guardian-medication cannuall unused medications. No medication usion of the school year.	medications at school. edications/health treatmentry label. actory label and not expire to be sent to school with a	e during the school year. a student.	
NAME OF MEDICATIO	DOSAGE	ROUTE	ADMINISTRATION TIME	
employees harmless from any an authorization.	d all liability foreseeable or unforeseeal	ble for damages or injury r	resulting directly or indirectly from	
Print Name:	Prefe	Preferred Contact Number:		
Signature:		Date:		
, .		clude the medical manage ot as prescribed.	' '	
Prescriber Name/Title:	iber Name/Title:Office Phone:			
	Signature:Date:			
Address:		Office	Fax:	
•	RATION AUTHORIZATION (Con h the student UNLESS both physician/ons only-Asthma inhalers, Epinephrine F	authorized prescriber and	parent provide authorization for the	
rescriber's authorization for self-ca	rry/self-administration of above me	dication:		
	f-carry/self-administration of above			