TRAVERSE CITY AREA PUBLIC SCHOOLS

MEDICATION/TREATMENT AUTHORIZATION FORM

For Office Staff
Self Carry: ☐

Other:_____

Name of Student _____ Birth Date _____

School _____ Grade _____

SECTION I - To be completed by the physician or licensed healthcare provider on all medications (REQUIRED):

Diagnosis/Purpose of medication/treatment (optional) _____

Name of medication/treatment _____

Dosage _____ Frequency _____ Time _____ MUST BE A SPECIFIC TIME (cannot say lunch time) Route _____ Start date _____ Stop date _____ Indefinite_____

Instructions, adverse reactions, storage requirements, etc._____

Physician's Signature _____ Date _____

Physician's Name (print or stamp) _____ Phone _____

Address _____

Traverse Area Pediatric
& Adolescent Clinic
4020 W. Royal Drive Traverse City, MI 49684
P 231.421.8099 F 231.421.8599

SECTION II - To be completed by parent/guardian (REQUIRED):

Medications and treatment supplies will be brought to school by the parent/guardian unless other safe arrangements are necessary and possible. All medication should be kept in a labeled container as prepared by a pharmacy, physician or pharmaceutical company and labeled with the student's name, route, dosage, and frequency. The prescription renewal and medication/treatment supply shall be the parent/guardian responsibility.

The student is responsible for presenting himself/herself on time and for taking the medication as prescribed. The undersigned parents/guardians shall notify the School District in writing in the event the prescription shall be discontinued.

I request that the medication/treatment be administered in conformance with the physician's/licensed health care provider's directions and according to the School District's policy. I give permission for the physicians/health care provider's staff and school district staff to share information needed to assist my child with medication needs. I have reviewed the Traverse City Area Public Schools Policy entitled "Administration of Medication to Students" and agree to abide by the terms.

Parent(s)/Guardian(s) Signature _____ Date _____

SECTION III - Self Administration to be completed by parent/guardian and student:

In certain circumstances students are permitted to self-administer medications and treatments. The decision to self-administer is determined by the student's health condition, their level of maturity and responsibility and the type of medication. Students shall not distribute or share their medication or he/she will be subject to disciplinary actions.

Elementary K –5	**Emergency medication only**
Middle School 6 – 8	**Emergency medication and medication that is not a controlled substance**
Senior High 9 – 12	**All medication**

I request that my child be allowed to self-administer the above medication according to school policy. I feel that they are both capable and responsible to hand carry and self-administer this medication.

Parent/Guardian _____ Date _____

Student Signature _____ Date _____

 ORIGINAL: School Office **COPY:** Email to District Nursing Department, Upload to Google Drive Rev. 9/99, 12/8/14, 4/29/20, 5/7/21