St. Mary-Hannah School
2912 West M-113
Kingsley, MI 49649
(231) 263-5288

Medication Treatment Authorization Form

Student Name _____ **Date of Birth** _____

Grade _____ **School Year 20**_____

SECTION I—To be completed by the physician or licensed health care provider on all medications (REQUIRED):

Diagnosis/Purpose of medication/treatment (optional) _____

Name of medication/treatment _____

Dosage _____ Frequency _____ 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 _____

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

Medications and treatment supplies will be brought to school by the legal 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 responsibility of the parent/guardian.

The student is responsible for presenting himself/herself on time and for taking the medication as prescribed. The undersigned parent/guardian shall notify the school in writing in the event that the prescription shall be discontinued.

I request that the medication/treatment be administered in performance with the physician's/licensed care provider's directions and according to the school's policy. I give permission for the physician's/health care provider staff and school staff to share information needed to assist my child in the medication needs. I have reviewed the school policy in the "St. Mary's Parent and Student Handbook" and agree to abide by the terms.

Parent/Guardian Signature _____ **Date** _____