Fruitport Community Schools
Authorization for Medications to be Taken During School Hours

The following section is to be completed by PARENT/GUARDIAN:

STUDENT NAME (LAST, FIRST) ADDRESS BIRTH DATE

SCHOOL BUILDING GRADE

(PARENT, PLEASE INITIAL EACH LINE)

_____ • I request that my child <u>be assisted</u> in taking the medicine(s) described below, at school by authorized personnel.

_____ • I will assume responsibility for safe delivery of the medication to the school office.

_____ • I will notify the school immediately in writing if there is any change in the use of the medication or the prescribed treatment.

_____ • I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ • I authorize staff affiliated with Fruitport Community Schools to exchange information concerning medication, medical history, or other pertinent medical information regarding my child.

_____ _____
Parent/Guardian Signature Date

_____ _____
Home Phone Cell Phone

The following is to be completed by your <u>PHYSICIAN for prescribed medications</u>, or by <u>PARENTS for non-prescribed medications</u>:

Diagnosis for which medication is given: _____

_____ _____
NAME OF MEDICATION DOSAGE (mg)

Time of day medication should be dispensed: _____

Termination date of medication: _____

If medication is to be given "when needed", describe indications: _____

_____

Other information: _____

_____ _____
Date PHYSICIAN'S SIGNATURE
(or parent's signature for non-prescription medicines)

Physicians please fax to: Fruitport Community Schools, Fruitport Middle School FAX (231) 865-4086
Questions, please call: (231) 865-3128

Medication Drop Off Log

Student's Name _____ Grade _____

Date	Name of Medication/Dosage	Number Dropped Off	Parent/Guardian Signature	Staff Initials