



Allendale Public Schools

District Nursing Office | 10690 Learning Lane, Allendale, MI 49401 | Office: (616) 892-3939 | Fax: (616) 895-9191

Permission Form for Non-Prescription (OTC) Medication

This form must be completed fully for APS staff to administer the specified medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication. Medication policy requirements include, but not limited to, the following:

- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the school.
- The school RN will call the parent/guardian and/or prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Student Demographics

This form is valid for the _____ - _____ school year (including summer session). Date: _____ School: _____
Name of Student: _____ DOB: _____ Teacher/Grade: _____

Medication Information

Condition for which medication is being administered: _____
Name of medication: _____ Dose: _____ Route: _____
Time/frequency of medication (at school): _____ If as needed, frequency: _____
Medication shall be administered from (date): _____ / _____ / _____ to _____ / _____ / _____
If as needed, for what symptoms: _____
Relevant side effects: ☐ None expected ☐ Specify: _____
Form of medication: ☐ Tablet/capsule ☐ Liquid ☐ Topical ☐ Other: _____ Taken the medication before: ☐ Yes ☐ No
Special Storage Requirements: ☐ None ☐ Specify: _____
Special Instructions/Precautions: ☐ None ☐ Specify: _____
Physician's Name: _____ Office Phone: _____

Medication Parent/Guardian Authorization

I/We request designated school personnel to administer the medication as written above. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA with proper medical release of information documentation.

Parent/Guardian Signature: _____ **Date:** _____
Phone Number: _____ ☐ Home ☐ Cell ☐ Work