TRAVERSE CITY CHRISTIAN SCHOOLS
753 Emerson Rd – Traverse City, MI 49696 • (231) 929-1747 • Fax: (231) 929-1831

Prescription Medication/Treatment Authorization Form – 2012/2013

Student Name _____ _____/_____/_____
(Last) (First) Birthdate

Section 1

This section must be completed by Physician

Medication name	Dose	Frequency	Form/Route *	Diagnosis/Purpose of Medication/Treatment

*** Form/Routes**
Oral (pill/capsule/chewable/liquid) **Inhaled** (Inhaler/Nebulizer) **Topical** (eye drop, ointment, lotion) **Injection** **Other**-List

List the minimal frequency between doses: _____

List symptoms/conditions under which medication is to be given: _____

_____

Instructions, Adverse Reactions, Storage Requirements: _____

_____

Start Date: _____ **Stop Date**: _____ **Indefinite** _____

Student is taking other prescribed medications at school. Yes or No _____ Please fill out a new form for each medication.

_____ _____ _____
Physician's Signature Physician's Printed Name Date

_____ _____
Physicians Phone Number Physician's Address

Section 2

This section must be completed by Parent/Guardian

So that _____(child 's name) may receive medication on the Traverse City Christian Schools (TCCS) property, in accordance with school policy, I authorize _____(Medication Prescribers) to release to the Administration of TCCS and the employees of TCCS designated by him, the information requested on the above section regarding the medications taken by my child, the reasons said medications were prescribed, the symptoms for which said medication should be given and any other information needed by the TCCS Administration and its employees to assist my child with medication needs. This authorization shall continue until the end of the current academic school year of TCCS. I may revoke this authorization in writing. If this authorization is revoked, any person or entity acting in good faith in reliance upon it, and lacking knowledge of its revocation, shall be held harmless. This authorization is intended to comply with the core elements and statements required by 45 CFR 164.508(c), or such subsequent regulations as may be issued, and is to be so interpreted.

I release the school administration and all teachers and other school employees designated by the school administration, who in good faith administer medication to my child in the presence of another adult or in an emergency that threatens the life or health of my child, pursuant to my written permission and in compliance with the instructions of a physician, physician's assistant or certified nurse practitioner, from criminal liability and civil damages as a result of an act or omission in the administration of the medication, except for an act or omission amounting to gross negligence or willful or wanton misconduct.

I, as parent/guardian acknowledge that I am required to bring medication in its original container and it is my responsibility to supply/renew the prescription and medication/treatment for my child.

_____ _____
Parent/Guardian Signature Date

Emergency Medication Section

In certain circumstances students are permitted to self-administer emergency 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.

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

_____ _____ _____ _____
Parent/Guardian Signature Date Student's Signature Date

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Over-the-Counter Medication/Treatment Authorization Form – 2011/2012

Student Name _____ _____/_____/_____
(Last) (First) Birthdate

Medication # 1	Dose	Frequency	Form/Route *	Diagnosis/Purpose of Medication/Treatment

*** Form/Routes**
Oral (pill/capsule/chewable/liquid) **Inhaled** (Inhaler/Nebulizer) **Topical** (eye drop, ointment, lotion) **Injection** **Other**-List

List the minimal frequency between doses: _____

List symptoms/conditions under which medication is to be given: _____

Instructions, Adverse Reactions, Storage Requirements: _____

Start Date: _____ Stop Date: _____ Indefinite _____

Medication #2	Dose	Frequency	Form/Route *	Diagnosis/Purpose of Medication/Treatment

*** Form/Routes**
Oral (pill/capsule/chewable/liquid) **Inhaled** (Inhaler/Nebulizer) **Topical** (eye drop, ointment, lotion) **Injection** **Other**-List

List the minimal frequency between doses: _____

List symptoms/conditions under which medication is to be given: _____

Instructions, Adverse Reactions, Storage Requirements: _____

Start Date: _____ Stop Date: _____ Indefinite _____

Medication #3	Dose	Frequency	Form/Route *	Diagnosis/Purpose of Medication/Treatment

Oral (pill/capsule/chewable/liquid) **Inhaled** (Inhaler/Nebulizer) **Topical** (eye drop, ointment, lotion) **Injection** **Other**-List

List the minimal frequency between doses: _____

List symptoms/conditions under which medication is to be given: _____

Instructions, Adverse Reactions, Storage Requirements: _____

Start Date: _____ Stop Date: _____ Indefinite _____

This section must be completed by parent/guardian

I request and give permission for **(name of child)** _____ to receive the above medication/treatment at school according to standard school. I, as parent/guardian acknowledge that I am required to bring medication in its original container and it is my responsibility to supply/renew the medication/treatment for my child.
I release the school administration and all teachers and other school employees designated by the school administration who in good faith administer medication to my child in the presence of another adult or in an emergency that threatens the life or health of my child, pursuant to my written permission, from criminal liability and civil damages as a result of an act or omission in the administration of the medication, except for an act or omission amounting to gross negligence or willful or wanton misconduct.

_____ _____
Parent/Guardian Signature Parent/Guardian Signature

_____ _____
Date Date