East Lansing Public Schools

Consent for Student to Self-Administer Medication Form

Student Information

Student's Name: _____

Date of Birth: _____ Grade: _____

Medication Name: _____ Dose: _____

Administration Method: _____ Administration Time/Frequency: _____

Directions: _____

If "as needed", under what conditions is the medication to be administered:

_____

Relevant Side Effects: _____

Healthcare Provider Information

This student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes - Supervised ☐ Yes - Unsupervised

This student may carry this medication: ☐ Yes ☐ No

Note: The final decision for students to take responsibility for medication will be made by the parent, building principal, teacher, and nurse. If the student does not use the medication responsibly, the school will take the medication and contact the family.

Please indicate if you have provided additional information: ☐ On the backside of this form ☐ As an attachment

Physician's Name: _____ Telephone Number:_____

Address: _____ City: _____

Fax Number: _____

Physician's Signature:_____ Date: _____

East Lansing Public Schools

Parent/Guardian Consent

I, _____, give permission for my Student to possess and administer medication in accordance with this form and applicable Policies. I acknowledge that Board Policy requires that I inform the District of any changes to the healthcare/provider's medication instructions immediately.

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

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

(Please circle which phone number you would like the District staff to call first.)