Traverse City Area Public Schools
Medication and Treatment Authorization Form

SECTION I: Student Information Section

Please provide the student's identification and enrollment details.

Student Full Name: _____

Birth Date (MM/DD/YYYY): _____

School Name: _____

Grade Level: _____

SECTION II: Medication or Treatment Details

Requirement: *This section must be completed and signed by a physician or licensed healthcare provider for* ***all*** *medications (Prescription* ***AND*** *Over-the-Counter).*

Diagnosis or Purpose of Medication/Treatment (Optional): _____

Name of Medication or Treatment: _____

Dosage: _____

Frequency: _____

Specific Time of Administration: _____ *(Note: Must be a specific time. "Lunch time" is not acceptable.)*

Route of Administration: _____

Start Date (MM/DD/YYYY): _____

Stop Date (MM/DD/YYYY): _____

Special Instructions, Adverse Reactions, or Storage Requirements: _____

Physician / Licensed Healthcare Provider Authorization

Physician Signature: _____

Date (MM/DD/YYYY): _____

Physician Name (Printed or Stamped): _____

Phone Number: _____

Clinic/Medical Address: _____

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SECTION III: Parent or Guardian Authorization

Requirement: *This section* ***must*** *be completed and signed by the parent or guardian.*

Terms and Policy Agreement

- Medications and treatment supplies must be brought to school by the parent or 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. The label must include the student's name, route, dosage, and frequency.
- Prescription renewal and ensuring an adequate supply of medication or treatment materials is the sole responsibility of the parent or guardian.
- The student is responsible for presenting himself or herself on time and for taking the medication as prescribed.
- The undersigned parents or guardians must notify the School District in writing immediately in the event the prescription is discontinued.
- I request that the medication or treatment be administered in conformance with the physician or licensed health provider's directions and according to the School District's policy.
- I give permission for the physicians or health care provider's staff and school district staff to share information needed to assist my child with medication needs.
- I have reviewed the Traverse City Area Public Schools Policy entitled "Administration of Medication to Students" and agree to abide by the terms.

Parent/Guardian Signature: **Date (MM/DD/YYYY):**

SECTION IV: Self-Administration Request

Requirement: *This section must be completed by both the* ***parent/guardian*** *and the* ***student only*** *if requesting permission for the student to self-administer medication.*

Self-Administration Eligibility Rules by Grade Level

The decision to allow self-administration is based on the student's health condition, maturity level, responsibility, and the specific type of medication. Students are strictly prohibited from distributing or sharing their medication; doing so will subject them to disciplinary action.

Student Grade Level	Allowed Medication Types for Self-Administration
Elementary School (Grades K – 5)	Emergency medication only
Middle School (Grades 6 – 8)	Emergency medication and medication that is not a controlled substance
Senior High School (Grades 9 – 12)	All medication

Self-Administration Agreement and Authorizations

Parent/Guardian Signature: _____

Date (MM/DD/YYYY): _____

Student Signature: _____

Date (MM/DD/YYYY): _____

Distribution Instructions: **Duplication of this form is permitted by TCAPS.** Original copies are held at the School Office. Copies are emailed to the District Nursing Department and uploaded to Google Drive.