Hopkins Public Schools

"Committed to Quality Education for our Children's Future"

400 CLARK STREET - HOPKINS, MI 49328 - (269) 793-7261 - FAX (888) 557-7919 - www.hpsvikings.org

Permission Form for Non-Prescription (OTC) Medication

This form must be completed fully for HPS 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 unopened 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 request designated school personnel to administer the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA with proper medical release of information documentation.
- I request designated school personnel to administer the medication as written above. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA with proper medical release of information documentation.
- I will assume responsibility for safe delivery of the medication to school.
- I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- Our physician has instructed that this medication should be administered in the above designated dosage.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature: _____ Date: _____

Phone Number: _____ Home Cell ☐ Work