TRAVERSE CITY AREA PUBLIC SCHOOLS
MEDICATION/TREATMENT AUTHORIZATION FORM

Name of Student ___________________________________________ Birth Date ____________________

School ____________________________________________________ Grade ___________________

SECTION I - To be completed by the physician or licensed healthcare provider on all medications (REQUIRED):

Diagnosis/Purpose of medication/treatment (optional) ________________________________________________

Name of medication/treatment __________________________________________________________________

Dosage __________________ Frequency __________ Time __________ Route ____________ Start date _____________ Stop date _________ Indefinite

Instructions, adverse reactions, storage requirements, etc.___________________________________________________________

Physician’s Signature ______________________________________ Date _____________________

Physician’s Name (print or stamp) ______________________________________ Phone ___________________

Address ____________________________________________________________________________________

SECTION II - To be completed by parent/guardian (REQUIRED):

Medications and treatment supplies will be brought to school by the parent/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 and labeled with the student’s name, route, dosage, and frequency. The prescription renewal and medication/treatment supply shall be the parent/guardian responsibility.

The student is responsible for presenting himself/herself on time and for taking the medication as prescribed. The undersigned parents/guardians shall notify the School District in writing in the event the prescription shall be discontinued.

I request that the medication/treatment be administered in conformance with the physician’s/licensed health care provider’s directions and according to the School District’s policy. I have reviewed the Traverse City Area Public Schools Policy entitled "Administration of Medication to Students" and agree to abide by the terms.

Parent(s)/Guardian(s) Signature ___________________________ Date _________________

SECTION III - Self Administration to be completed by parent/guardian and student:

In certain circumstances students are permitted to self-administer 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. Students shall not distribute or share their medication or he/she will be subject to disciplinary actions.

Elementary K – 5 Emergency medication only
Middle School 6 – 8 Emergency medication and medication that is not a controlled substance
Senior High 9 – 12 All medication

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

Parent/Guardian ______________________________________ Date _________________

Student Signature ______________________________________ Date _________________

Duplication of this form is permitted by TCAPS.

ORIGINAL: School Office
COPY: Email to District Nursing Department, Upload to Google Drive

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