VAN BUREN PUBLIC SCHOOLS

ADMINISTRATION BUILDING

555 W. Columbia Ave.
Belleville, MI 48111
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Consent for District Administered Medication Form 2023-2024 School Year

(A new form is required each school year for each medication)

Student Information

Student's Name: _____Date Of Birth: _____

School: _____Grade: _____

Healthcare Provider Information

This section MUST be completed by the student's healthcare provider

Provider Stamp

Name/Title:_____

Address:_____

Telephone:_____ Fax: _____

Medication Information

Medication name_____ Dose: _____Form of Medication_____

Reason For Medication: _____ Start Date: _____ End Date: _____

Administration Method: _____ Administration Time/Frequency: _____

If *as needed* under what conditions is the medication to be administered:_____

Relevant Side Effects:

_____

Provider Signature: _____ Date: _____

Parent/Guardian Consent

I, _____, authorize school staff to administer medication accordance with this form and applicable policies. I acknowledge that Board Policy requires that I immediately inform the District of any changes to the healthcare provider's medication instructions.