

**FOREST HILLS PUBLIC SCHOOLS**  
Grand Rapids, Michigan  
**MEDICATION AUTHORIZATION FORM**

This form should be completed when a student requires daily medication administration or an over-the-counter as needed medication during school hours. Please remember all medications must be brought to school by a parent/guardian/adult and be in its original container. This form is **NOT** for emergency medications such as metered-dose inhalers and emergency injectable/nasal medications. Emergency medications require an Emergency Action Plan (EAP). All forms can be found on the district website or in your school building.

Student \_\_\_\_\_ Date of birth \_\_\_\_\_  
Grade \_\_\_\_\_ School/Teacher \_\_\_\_\_ School Fax \_\_\_\_\_

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Name of medication: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Method of administration:

Tablet/Capsule     Liquid     Inhaler     Injection     Nebulizer     Other \_\_\_\_\_

Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Time(s): \_\_\_\_\_

Start date: \_\_\_\_\_ Stop date: \_\_\_\_\_ (if applicable)

Should the school be aware of any adverse reactions or precautions? \_\_\_\_\_

Special storage requirements:     None     Refrigerate     Other \_\_\_\_\_

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**Self-Administering Medications only**  
**7<sup>th</sup>/8<sup>th</sup> grade over-the-counter medications only!**  
**9<sup>th</sup> thru 12<sup>th</sup> grade over-the-counter and prescription medications!**

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

No     Yes - supervised     Yes - unsupervised

This student may carry one dose of this medication on him/her:     Yes     No

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**For all prescription medications, a physician signature is required.**

Signature of Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Printed name of Health Care Provider: \_\_\_\_\_ Fax: \_\_\_\_\_

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I request FHPS to administer the above medication as prescribed according to the standard school policy.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date