Grandville Public Schools

Health Room Office
4700 Canal SW
Grandville, Michigan 49418
Phone: (616) 254.6455 Fax: (616) 254.6462

Medication Administration Directions

Student _____ Date _____
Date of Birth _____ Grade _____
School _____ School Phone _____ FAX _____

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Name of Medication _____

Reason for Medication (Optional) _____

Form of Medication

___Tablet/capsule ___Liquid ___Inhaler ___Nebulizer ___Injection ___Pump

___Other (Describe)_____

Dosage for school administration _____

Time/s for school administration:_____

Special Instructions _____

Signature of Physician _____ Date _____
(For prescription medications kept longer than 2 weeks)

Type/Print Name of Physician _____ Phone _____

To be completed by Parent or Guardian

I hereby request and authorize school personnel to administer my child's medication. School personnel may contact the office of my child's physician for concerns related to the administration of this medication. I understand that I must bring the medication to school myself, and that a new form must be completed for any change in medication.

Signed _____ Date _____
(Parent/Guardian)

Phone Number for Parents: Home _____ Cell _____ Work _____

NOTES

STUDENT NAME:_____

DATE	NOTES

Amount of meds brought:

DATE								
AMOUNT								

Meds Destroyed:

Date:_____ **By:**_____

Amount:_____ **Witness:**_____