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
Mildred 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: Mail, Email or Fax to District Health Coordinator

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