# RCAPS Permission for Medication

**Reed City Area Public Schools**
225 W. Church Avenue, Suite A
Reed City, Michigan 49677

School Building: ❑GT Norman Elementary ❑Reed City Middle School ❑Reed City High School

Student: _____ Today's Date: ____/____/_____ Academic Year:_____

DOB: ____/____/_____ Age: _____ Grade: _____ Teacher (K-5): _____

❑ Form Reviewed by District Nurse / Authorized RCAPS Staff: _____

**Prescription Medication.** **This section MUST be completed by the PHYSICIAN or AUTHORIZED PRESCRIBER**

Name of Medication:_____ Reason for Use: _____

Form of Medication/Treatment: ❑Tablet/Capsule ❑Liquid ❑Inhaler ❑Injection ❑Nebulizer ❑Ointment ❑Other _____

**Instructions** *(schedule and dose to be given at school):* _____

*Student is capable and responsible for **self-administering** the above prescription: ❑Yes-Unsupervised ❑Yes-Supervised ❑No

**Physician's Name** (Printed): _____ **Phone:** _____

**Physician's Signature:** _____ **Date:** ____/____/_____

I give permission for my child, _____, to receive the above medication at school in accordance with RCAPS Medication Administration Policy. *(RCAPS requires parent/guardian deliver medication to school and medication is **kept in the original container**).*

**Parent/Guardian Signature** _____ **Relationship** _____ **Date** ____/____/_____

**Over the Counter Medication (OTC) & Treatments .** **This section MUST be completed by PARENT or GUARDIAN**

Name of Medication:_____ Reason for Use: _____

Form of Medication/Treatment: ❑Tablet/Capsule ❑Liquid ❑Inhaler ❑Injection ❑Nebulizer ❑Ointment ❑Other _____

**Instructions** *(schedule and dose to be given at school):* _____

I give permission for my child, _____, to receive the above medication at school in accordance with RCAPS Medication Administration Policy. *(RCAPS requires parent/guardian deliver medication to school and that it is **kept in the original container**).*

**Authorization also includes permission for school personnel and/or health care provider to contact each other as needed. Medication and Treatment information is kept confidential but may be shared with appropriate school staff, administration, health care personnel, or emergency services.**

**Parent/Guardian Signature** _____ **Relationship** _____ **Date** ____/____/_____

**SELF ADMINISTER/SELF-CARRY EMERGENCY MEDS.** **This section MUST be completed by PARENT or GUARDIAN**

*Student is capable and responsible for **self-administering** emergency Rx: ❑Yes-Unsupervised ❑Yes-Supervised ❑No
*Students, in grades 6-12, may **self-carry** a **single dose** of emergency medication ONLY with signed permission and ONLY when in original container.

I give permission for my child, _____, to ❑self-administer ❑self-carry the above medication at school in accordance with RCAPS Self- Administration Policy.

**Authorization also includes permission for school personnel and/or health care provider to contact each other as needed. Medication and Treatment information is kept confidential but may be shared with appropriate school staff, administration, health care personnel, or emergency services.**

**Parent/Guardian Signature** _____ **Relationship** _____ **Date** ____/____/_____