Grand Rapids Public Schools



Health Services

Health Services proudly supports Grand Rapids Public Schools scholars and their families by promoting health, maintaining a safe environment, preventing disease, and minimizing the impact of disability.

What is the role of the School Nurse?

School nursing, a specialized practice of nursing, protects and promotes student health, facilitates optimal development, and advances academic success. School nurses, grounded in ethical and evidence-based practice, are the leaders who bridge health care and education, provide care coordination, advocate for quality student-centered care, and collaborate to design systems that allow individuals and communities to develop their full potential. Adopted by the National Association of School Nurses (https://www.nasn.org/home) Board of Directors February 2017.

Health Services Resources

Cherry Health School-Based Health Centers

We are proud to partner with Cherry Health to provide School-Based Health Centers that offer high quality care for scholars in a convenient, school-friendly environment. Healthcare services are located steps away from the classroom where interruptions to the educational process are kept at a minimum.

Request An Appointment at a Cherry Heath (/departments/health-

3 Convenient Locations:

Innovation Central High School Health Center
421 Fountain St NE, Grand Rapids, MI 49503 (https://maps.app.goo.gl/oPoofeRwWjDppwEM7)
(616) 776-5110 (tel:6167765110)
Innovation Central Health Center Webpage (https://www.cherryhealth.org/find-location/innovation-central/)

Ottawa Hills High School Health Center
2055 Rosewood Ave S, Grand Rapids, MI 49506 (https://maps.app.goo.gl/W3ujJ7YzS6M7NaRR6)
(616) 776-5110 (tel:6167765110)
Ottawa Hills Health Center Webpage (https://www.cherryhealth.org/find-location/ottawa-hills-high-school-health-center/)

Union High School Health Center
1800 Tremont Blvd NW, Grand Rapids, MI 49504 (https://maps.app.goo.gl/3BJ8UmAPR7CrNAGc6)
(616) 776-5110 (tel:6167765110)
Union Health Center Webpage (https://www.cherryhealth.org/find-location/union-high-school-health-center/)

Special thank you to our healthcare partner:

Cherry Health
Comprehensive. Quality. *Healthcare.*
(https://www.cherryhealth.org/)

Catherine's Health School-Based Health Center

We are proud to partner with Catherine's Health Center to provide a school-based health center at Harrison Park Academy that offer high quality care for scholars in a convenient, school-friendly environment. Healthcare services are located steps away from the classroom where interruptions to the educational process are kept at a minimum. Any child between the ages of 3-21 years of age can receive medical or behavioral health services.

Harrison Park Health Center
1440 Davis Ave NW, Grand Rapids, MI 49504 (https://maps.app.goo.gl/iCHbbP7JwscgkkaB8)

(616) 315-2852 (tel:6163152852)

Harrisonfront@catherineshc.org (mailto:Harrisonfront@catherineshc.org)

Parental Consent Form (https://form.jotform.com/252114691871054)

Immunizations Requirements & Resources

Whenever children are brought into group settings, there is a chance for diseases to spread. Taking preventive steps through immunizations can protect scholars and help ensure a safe learning environment.

Immunization Requirements

Any scholar who is not up-to-date with immunization requirements shall be excluded from school until required immunizations have been administered. School personnel shall cooperate with public health officials in completing and coordinating all immunization data, waivers and exclusions.

Immunization Waivers

A student is only exempt from the immunization requirements if the parent or guardian presents a written and signed waiver to their school administrators indicating their objections to immunizations based on religious, medical or other factors. Philosophical or religious immunization waivers can only be obtained through the Kent County Health Department. Please contact your school nurse for more information.

Learn more about how you can prevent the spread of disease from the Kent County Health Department (https://www.accesskent.com/Health/Immunizations/) (KCHD).

Take the next step and schedule your child's immunization by clicking the button below.

View the KCHD Immunization Schedule (https://www.accesskent.com/Health/Immunizations/schedules.htm)

Health Services Forms

Cherry Health

Screening Checklist for Contraindications to Vaccines

Patient Name: _____ Date of Birth: _____ / _____ / _____

For patients or parents/guardians: The following questions will help us decide which vaccines you or your child can receive today. If you answer "yes" to any question, it does not necessarily mean you or your child should not be vaccinated. It just means we need to ask additional questions. Please ask your healthcare provider to explain if any of the questions are unclear.

Answer each question for the person being vaccinated today.	Yes	No	Unsure
1. Is the patient sick today?			
2. Does the patient have allergies to medications, food, a vaccine ingredient, or latex?			
3. Has the patient ever had a serious reaction after receiving any vaccine?			
4. Does the patient have long-term health problem with heart, lung, kidney, metabolic disease (ie. Diabetes), asthma, a blood clotting disorder, no spleen, complement component deficiency, cochlear implant, or spinal fluid leak? Is the patient on long-term aspirin therapy?			
5. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
6. Does the patient have a sibling or parent with an immune system problem?			
7. In the past 3 months, has the patient taken medicines that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatment?			
8. Has the patient had a seizure? Any brain or other nervous system problem? Has a sibling or parent of the patient had any seizures?			
9. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
10. Is the patient pregnant or chance of pregnancy during the next month?			
11. Has the patient received any vaccinations in the past 4 weeks?			
12. Has the patient ever felt dizzy or faint before, during or after a shot?			
13. Is the patient anxious about getting a shot?			
14. For children between the ages of 2-4 years old, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
15. For babies between the ages of birth-8 months old, have you ever been told he/she has had intussusception?			
16. Has the patient ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?			

Form #495C Rev 10/31/2024 1 of 2
Scan to immunizations

Cherry Health Vaccine Screening Checklist

View PDF Form

Cherry Health

Lista de verificación de detección de contraindicaciones para vacunas

Nombre del paciente: _____ Fecha de nacimiento: _____ / _____ / _____

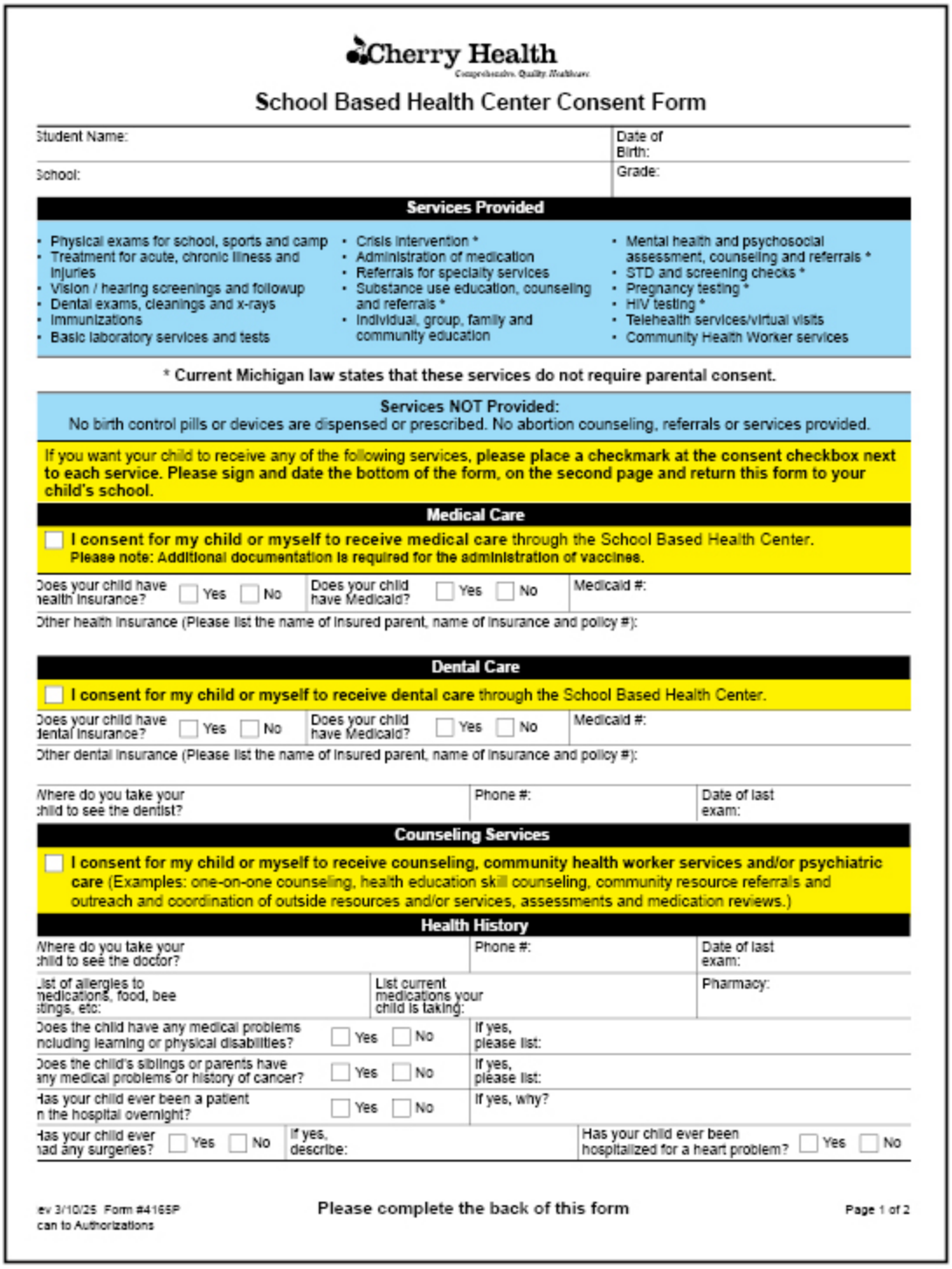
Para pacientes o padres/tutores: Las siguientes preguntas nos ayudarán a decidir qué vacunas usted o su hijo pueden recibir hoy. Si responde "sí" a cualquier pregunta, no significa necesariamente que usted o su hijo no deban vacunarse. Simplemente significa que debemos hacer preguntas adicionales. Pídale a su proveedor de atención médica que le explique si alguna de las preguntas no está clara.

Responda cada pregunta para la persona que se vacunará hoy.	Sí	No	Inseguro
1. ¿El paciente está enfermo hoy?			
2. ¿Tiene el paciente alergias a medicamentos, alimentos, algún ingrediente de la vacuna o al látex?			
3. ¿Alguna vez el paciente ha tenido una reacción grave después de recibir alguna vacuna?			
4. ¿Tiene el paciente un problema de salud a largo plazo con el corazón, pulmón, riñón, enfermedad metabólica (es decir, diabetes), asma, un trastorno de coagulación sanguínea, falta de bazo, deficiencia de componentes del complemento, implante coclear o fuga de líquido cefalorraquídeo? ¿Está el paciente bajo tratamiento con aspirina a largo plazo?			
5. ¿Tiene el paciente cáncer, leucemia, VIH/SIDA o algún otro problema del sistema inmunológico?			
6. ¿Tiene el paciente algún hermano o padre con un problema del sistema inmunológico?			
7. En los últimos 3 meses, ¿el paciente ha tomado medicamentos que afectan su sistema inmunológico, como prednisona, otros esteroides o medicamentos contra el cáncer? medicamentos para el tratamiento de la artritis reumatoide, la enfermedad de Crohn o la psoriasis; o recibió tratamiento de radiación?			
8. ¿El paciente ha tenido una convulsión? ¿Algún problema cerebral u otro sistema nervioso? ¿Algún hermano o padre del paciente ha tenido convulsiones?			
9. En el último año, ¿el paciente recibió una transfusión de sangre o productos sanguíneos, o recibió inmunoglobulina (gamma) o un medicamento antiviral?			
10. ¿La paciente está embarazada o hay posibilidades de embarazo durante el próximo mes?			
11. ¿Ha recibido el paciente alguna vacuna en las últimas 4 semanas?			
12. ¿Alguna vez el paciente se ha sentido mareado o desmayado antes, durante o después de una inyección?			
13. ¿El paciente se pone ansioso por recibir una inyección?			
14. Para niños entre 2 y 4 años de edad, ¿le ha dicho un proveedor de atención médica que el niño tuvo sibilancias o asma en los últimos 12 meses?			
15. En el caso de bebés desde el nacimiento hasta los 8 meses de edad, ¿alguna vez le han dicho que ha tenido intususcepción intestinal?			
16. ¿Alguna vez le han diagnosticado al paciente una afección cardíaca (miocarditis o pericarditis) o ha tenido síndrome inflamatorio multisistémico (MIS-A o MIS-C) después de una infección con el virus que causa el COVID-19?			

Form #495C Rev 10/31/2024 1 of 2
Scan to immunizations

Lista de Verificación de Detección de Contraindicaciones para Vacunas

Ver formulario PDF



Cherry Health
Comprehensive. Quality. Healthcare.

School Based Health Center Consent Form

Student Name:	Date of Birth:
School:	Grade:

Services Provided

- Physical exams for school, sports and camp
- Treatment for acute, chronic illness and injuries
- Vision / hearing screenings and followup
- Dental exams, cleanings and x-rays
- Immunizations
- Basic laboratory services and tests
- Crisis intervention *
- Administration of medication
- Referrals for specialty services
- Substance use education, counseling and referrals *
- Individual, group, family and community education
- Mental health and psychosocial assessment, counseling and referrals *
- STD and screening checks *
- Pregnancy testing *
- HIV testing *
- Telehealth services/virtual visits
- Community Health Worker services

* Current Michigan law states that these services do not require parental consent.

Services NOT Provided:
No birth control pills or devices are dispensed or prescribed. No abortion counseling, referrals or services provided.

If you want your child to receive any of the following services, please place a checkmark at the consent checkbox next to each service. Please sign and date the bottom of the form, on the second page and return this form to your child's school.

Medical Care

☐ I consent for my child or myself to receive medical care through the School Based Health Center.
Please note: Additional documentation is required for the administration of vaccines.

Does your child have health insurance? ☐ Yes ☐ No	Does your child have Medicaid? ☐ Yes ☐ No	Medicaid #:

Other health insurance (Please list the name of insured parent, name of insurance and policy #):

Dental Care

☐ I consent for my child or myself to receive dental care through the School Based Health Center.

Does your child have dental insurance? ☐ Yes ☐ No	Does your child have Medicaid? ☐ Yes ☐ No	Medicaid #:

Other dental insurance (Please list the name of insured parent, name of insurance and policy #):

Where do you take your child to see the dentist?	Phone #:	Date of last exam:

Counseling Services

☐ I consent for my child or myself to receive counseling, community health worker services and/or psychiatric care (Examples: one-on-one counseling, health education skill counseling, community resource referrals and outreach and coordination of outside resources and/or services, assessments and medication reviews.)

Health History

Where do you take your child to see the doctor?		Phone #:	Date of last exam:
List of allergies to medications, food, bee stings, etc:	List current medications your child is taking:		Pharmacy:
Does the child have any medical problems including learning or physical disabilities? ☐ Yes ☐ No		If yes, please list:	
Does the child's siblings or parents have any medical problems or history of cancer? ☐ Yes ☐ No		If yes, please list:	
Has your child ever been a patient in the hospital overnight? ☐ Yes ☐ No		If yes, why?	
Has your child ever had any surgeries? ☐ Yes ☐ No	If yes, describe:	Has your child ever been hospitalized for a heart problem? ☐ Yes ☐ No	

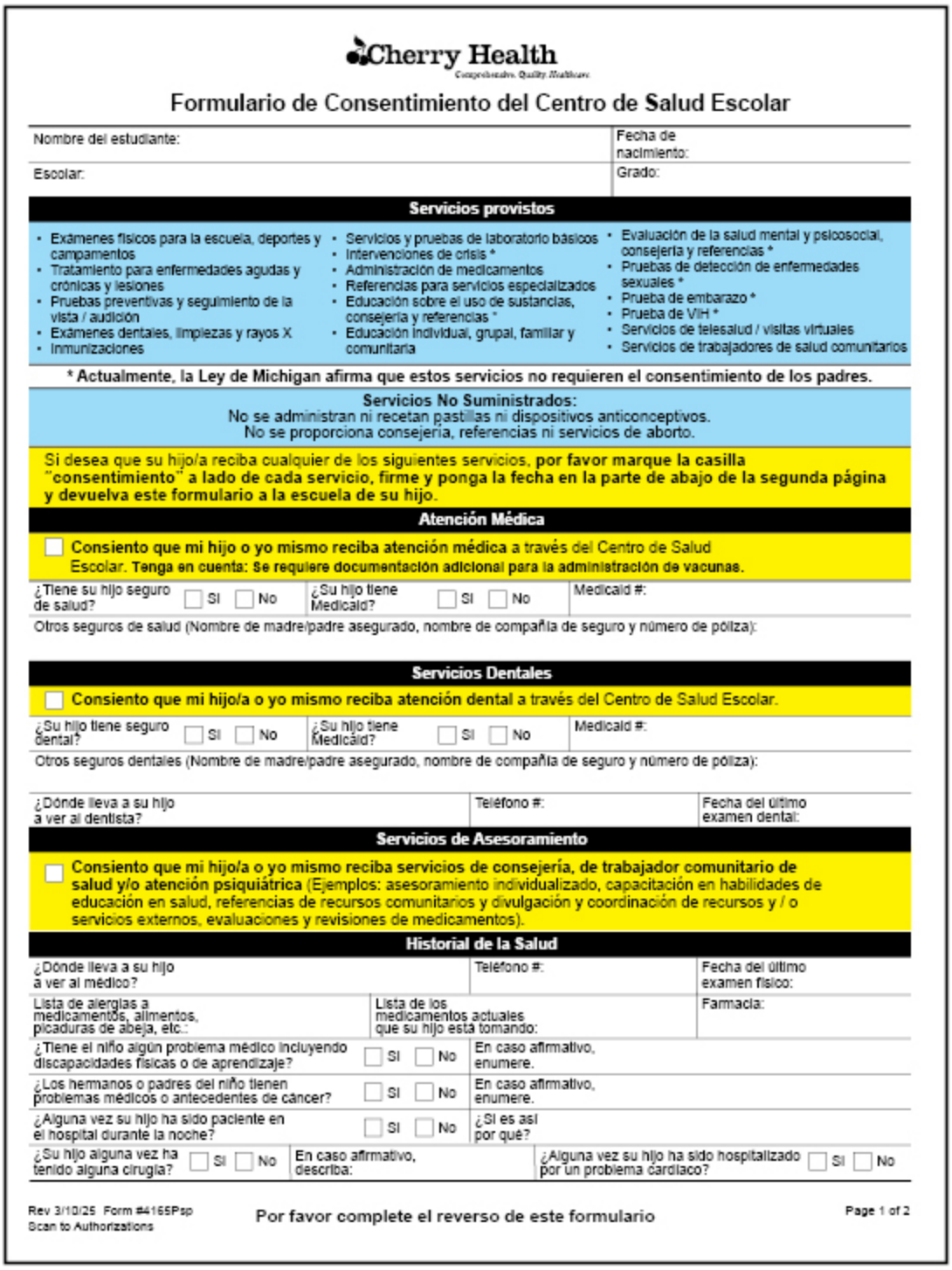
Rev 3/10/25 Form #4165P
Scan to Authorizations

Please complete the back of this form

Page 1 of 2

Cherry Health School-Based Health Center Consent Form

View PDF Form



Cherry Health
Comprehensive. Quality. Multicare.

Formulario de Consentimiento del Centro de Salud Escolar

Nombre del estudiante:	Fecha de nacimiento:
Escolar:	Grado:

Servicios provistos

- Exámenes físicos para la escuela, deportes y campamentos
- Tratamiento para enfermedades agudas y crónicas y lesiones
- Pruebas preventivas y seguimiento de la vista / audición
- Exámenes dentales, limpiezas y rayos X
- Inmunizaciones
- Servicios y pruebas de laboratorio básicos
- Intervenciones de crisis *
- Administración de medicamentos
- Referencias para servicios especializados
- Educación sobre el uso de sustancias, consejería y referencias *
- Educación individual, grupal, familiar y comunitaria
- Evaluación de la salud mental y psicosocial, consejería y referencias *
- Pruebas de detección de enfermedades sexuales *
- Prueba de embarazo *
- Prueba de VIH *
- Servicios de telesalud / visitas virtuales
- Servicios de trabajadores de salud comunitarios

*** Actualmente, la Ley de Michigan afirma que estos servicios no requieren el consentimiento de los padres.**

Servicios No Suministrados:
No se administran ni recetan pastillas ni dispositivos anticonceptivos.
No se proporciona consejería, referencias ni servicios de aborto.

Si desea que su hijo/a reciba cualquier de los siguientes servicios, por favor marque la casilla "consentimiento" a lado de cada servicio, firme y ponga la fecha en la parte de abajo de la segunda página y devuelva este formulario a la escuela de su hijo.

Atención Médica

☐ **Consiento que mi hijo o yo mismo reciba atención médica** a través del Centro de Salud Escolar. **Tenga en cuenta: Se requiere documentación adicional para la administración de vacunas.**

¿Tiene su hijo seguro de salud? ☐ SI ☐ No	¿Su hijo tiene Medicaid? ☐ SI ☐ No	Medicaid #:

Otros seguros de salud (Nombre de madre/padre asegurado, nombre de compañía de seguro y número de póliza):

Servicios Dentales

☐ **Consiento que mi hijo/a o yo mismo reciba atención dental** a través del Centro de Salud Escolar.

¿Su hijo tiene seguro dental? ☐ SI ☐ No	¿Su hijo tiene Medicaid? ☐ SI ☐ No	Medicaid #:

Otros seguros dentales (Nombre de madre/padre asegurado, nombre de compañía de seguro y número de póliza):

¿Dónde lleva a su hijo a ver al dentista?	Teléfono #:	Fecha del último examen dental:

Servicios de Asesoramiento

☐ **Consiento que mi hijo/a o yo mismo reciba servicios de consejería, de trabajador comunitario de salud y/o atención psiquiátrica** (Ejemplos: asesoramiento individualizado, capacitación en habilidades de educación en salud, referencias de recursos comunitarios y divulgación y coordinación de recursos y / o servicios externos, evaluaciones y revisiones de medicamentos).

Historial de la Salud

¿Dónde lleva a su hijo a ver al médico?	Teléfono #:	Fecha del último examen físico:
Lista de alergias a medicamentos, alimentos, picaduras de abeja, etc.:	Lista de los medicamentos actuales que su hijo está tomando:	Farmacia:
¿Tiene el niño algún problema médico incluyendo discapacidades físicas o de aprendizaje? ☐ SI ☐ No	En caso afirmativo, enumere.	
¿Los hermanos o padres del niño tienen problemas médicos o antecedentes de cáncer? ☐ SI ☐ No	En caso afirmativo, enumere.	
¿Alguna vez su hijo ha sido paciente en el hospital durante la noche? ☐ SI ☐ No	¿Si es así por qué?	
¿Su hijo alguna vez ha tenido alguna cirugía? ☐ SI ☐ No	En caso afirmativo, describa:	¿Alguna vez su hijo ha sido hospitalizado por un problema cardíaco? ☐ SI ☐ No

Rev 3/10/25 Form #4165Psp
Scan to Authorizations

Por favor complete el reverso de este formulario

Page 1 of 2

Formulario de Consentimiento del Centro de Salud Escolar

Ver formulario PDF

Grand Rapids Public Schools

Consent for Disclosure of Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools, State, and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the student's name, date of birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department.

You may withdraw your consent to share this information in writing at any time.

_____ I authorize Grand Rapids Public Schools to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.

_____ I DO NOT authorize Grand Rapids Public Schools to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department.

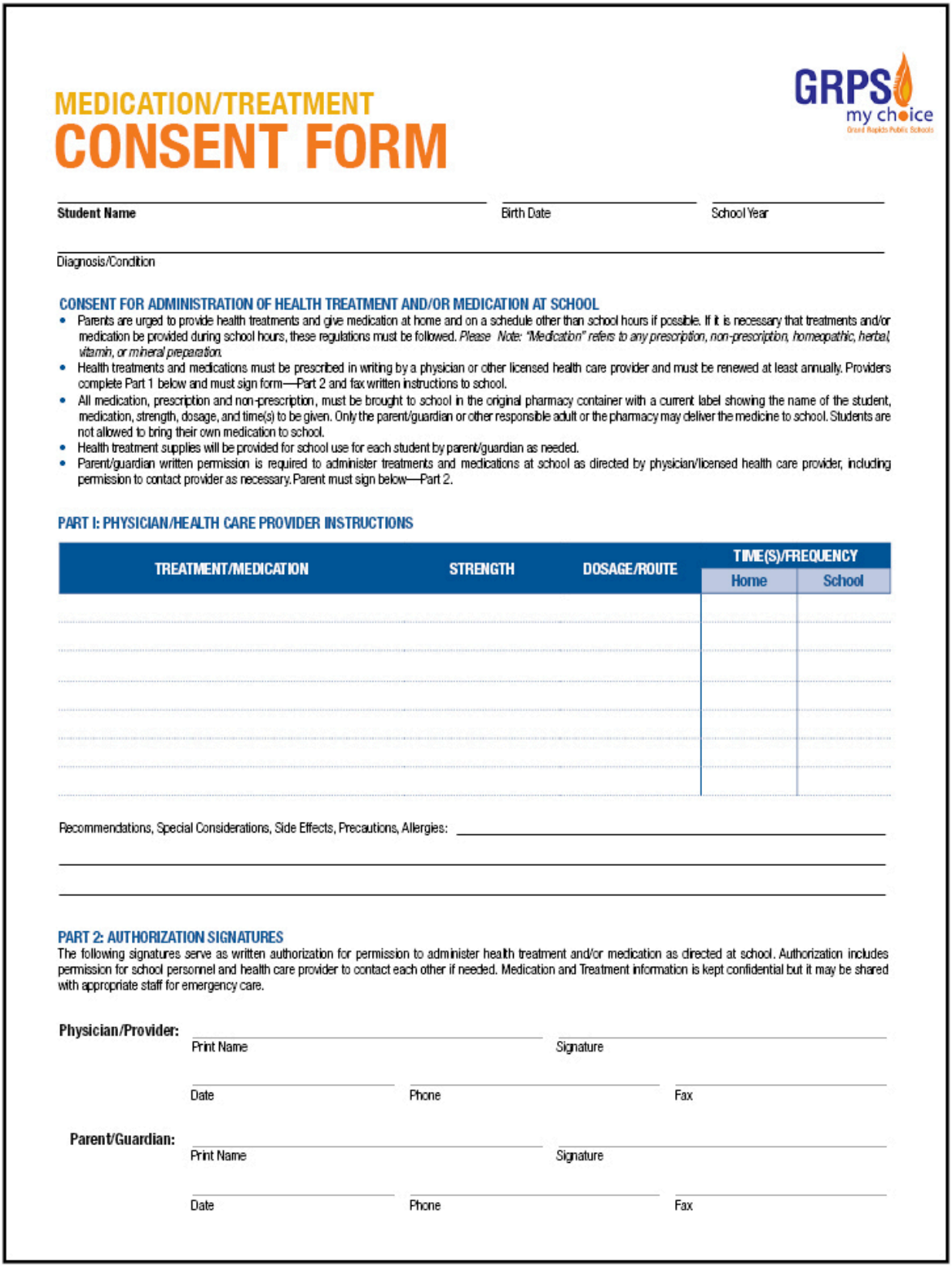
Student's Name: _____ Date of birth: ___ /___ /___

Signature of Parent/Guardian: _____ Date: ___ / ___ / ___

Printed Parent/Guardian name: _____

Consent for Disclosure of Immunization Information to Local and State Health Departments

View PDF Form



MEDICATION/TREATMENT
CONSENT FORM

GRPS my choice
Grand Rapids Public Schools

Student Name _____ Birth Date _____ School Year _____

Diagnosis/Condition _____

CONSENT FOR ADMINISTRATION OF HEALTH TREATMENT AND/OR MEDICATION AT SCHOOL

- Parents are urged to provide health treatments and give medication at home and on a schedule other than school hours if possible. If it is necessary that treatments and/or medication be provided during school hours, these regulations must be followed. *Please Note: "Medication" refers to any prescription, non-prescription, homeopathic, herbal, vitamin, or mineral preparation.*
- Health treatments and medications must be prescribed in writing by a physician or other licensed health care provider and must be renewed at least annually. Providers complete Part 1 below and must sign form—Part 2 and fax written instructions to school.
- All medication, prescription and non-prescription, must be brought to school in the original pharmacy container with a current label showing the name of the student, medication, strength, dosage, and time(s) to be given. Only the parent/guardian or other responsible adult or the pharmacy may deliver the medicine to school. Students are not allowed to bring their own medication to school.
- Health treatment supplies will be provided for school use for each student by parent/guardian as needed.
- Parent/guardian written permission is required to administer treatments and medications at school as directed by physician/licensed health care provider, including permission to contact provider as necessary. Parent must sign below—Part 2.

PART I: PHYSICIAN/HEALTH CARE PROVIDER INSTRUCTIONS

TREATMENT/MEDICATION	STRENGTH	DOSAGE/ROUTE	TIME(S)/FREQUENCY	
			Home	School

Recommendations, Special Considerations, Side Effects, Precautions, Allergies: _____

PART 2: AUTHORIZATION SIGNATURES

The following signatures serve as written authorization for permission to administer health treatment and/or medication as directed at school. Authorization includes permission for school personnel and health care provider to contact each other if needed. Medication and Treatment information is kept confidential but it may be shared with appropriate staff for emergency care.

Physician/Provider:
Print Name _____ Signature _____
Date _____ Phone _____ Fax _____

Parent/Guardian:
Print Name _____ Signature _____
Date _____ Phone _____ Fax _____

Medication/Treatment Consent Form

View PDF Form

MEDICATION/TREATMENT CONSENT FORM FOR SELF-ADMINISTRATION

GRPS my choice Grand Rapids Public Schools WWW.GRPS.ORG

Student Name _____ Birth Date _____ School Year _____

Diagnosis/Condition _____

CONSENT FOR ADMINISTRATION OF HEALTH TREATMENT AND/OR MEDICATION AT SCHOOL

- Parents are urged to provide health treatments and give medication at home and on a schedule other than school hours if possible. If it is necessary that treatments and/or medication be provided during school hours, these regulations must be followed. *Please Note: "Medication" refers to any prescription, non-prescription, homeopathic, herbal, vitamin, or mineral preparation.*
- Self-administration provisions are for high school students only with the exception of inhalers, epipens and glucagon.
- Health treatments and medications must be prescribed in writing by a physician or other licensed health care provider and must be renewed at least annually. Providers complete Part 1 below and must sign form—Part 2 and fax written instructions to school.
- All medication, prescription and non-prescription, must be brought to school in the original pharmacy container only with a current label showing the name of the student, medication, strength, dosage, and time(s) to be given. Metered dose inhalers must have a label attached to the container.
- Health treatment supplies will be provided for school use for each student by parent/guardian as needed.
- Parent/guardian written permission is required to administer treatments and medications at school as directed by physician/licensed health care provider, including permission to contact provider as necessary. Parent must sign below—Part 2.
- Any misuse of medication by a student, including selling or giving away the medication, that violates Grand Rapids Public Schools policies will result in revocation of self-administration privileges and may result in a referral to law enforcement officials. Please see the student handbook for Grand Rapids Public Schools policies regarding medication at school.

PART 1: PHYSICIAN/HEALTH CARE PROVIDER INSTRUCTIONS

TREATMENT/MEDICATION	STRENGTH	DOSAGE/ROUTE	TIME(S)/FREQUENCY	
			Home	School

Recommendations, Special Considerations, Side Effects, Precautions, Allergies: _____

PART 2: AUTHORIZATION SIGNATURES

The following signatures serve as written authorization for permission for student to self-administer health treatment and/or medication as directed at school. Authorization includes permission for school personnel and health care provider to contact each other if needed. Medication and Treatment information is kept confidential but it may be shared with appropriate staff for emergency care. *Please Note: School personnel will not supervise the medication administration or have responsibility in the process. Parent will be notified of any observed violation of the above guidelines.*

Physician/Provider: _____ Print Name _____ Signature

_____ Date _____ Phone _____ Fax

Parent/Guardian: _____ Print Name _____ Signature

_____ Date _____ Phone _____ Fax

Student: _____ Print Name _____ Signature

_____ Date _____ Phone _____ Fax

The District will not discriminate against any person based on race, sex, gender, height, weight, color, religion, national origin, age, marital status, disability or veteran status. The District's Compliance Coordinator is Ms. Sharron M. Pitts. You may contact her at: Grand Rapids Public Schools, 1331 Franklin St. SE, P.O. Box 117, Grand Rapids, Michigan 49501, humanresources@grps.org, (616) 819-2035.

Medication/Treatment Consent Form for Self-Administration

View PDF Form

RELEASE OF CONFIDENTIAL INFORMATION AND RECORDS

Kent Intermediate School District, Grand Rapids, Michigan

Student Name _____ Date of Request for Information/Records _____

Birthdate _____ Age _____ District/School _____

PROVIDER

We are requesting the specified information and records **from**:

Name _____ School/Agency _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ Fax _____

PURPOSE

The information and records are requested for the following purpose:

❑ Educational programming ❑ Other *(Specify)* _____

_____

REQUEST

Initials	Requested Information and Records
____	_____
____	_____
____	❑ Ongoing two-way written communication: _____
____	❑ Ongoing two-way verbal communication: _____
____	❑ Most recent progress reports and notes: _____
____	❑ Current Individualized Education Plan (IEP): _____
____	❑ Most recent evaluation team and diagnostic findings: _____

RECIPIENT

We are requesting the indicated information and records be **sent to**:

Name _____ School/Agency _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ Fax _____

Page 1 of 2 November 2015

Release of Confidential Information and Records

View PDF Form

Frequently Asked Questions

When should I keep my child home from school due to illness?

According to Grand Rapids Public Schools Communicable Disease Policy, Rules # 5141.2, parents will be informed to keep children home when they are ill. Students who have symptoms of communicable disease will be excluded from school.

These symptoms include:

- Fever 100.4 or higher or chills
- New cough or change in cough
- Shortness of breath or wheezing
- New loss of taste or smell
- Sore throat
- Body aches
- Diarrhea, vomiting, or nausea
- Severe headache
- Extreme tiredness
- Congestion or runny nose
- Sores on skin with pus or liquid drainage
- Stiff neck or back
- Unexplained rash

Please contact your school nurse if you have questions or would like to discuss your child's symptoms.

What if my child needs medication during the school day?

Parent(s)/Guardian(s) are urged to give medication and provide medical treatment at home and on a schedule other than school hours if possible. Medication includes prescription and non-prescription medication, homeopathic remedy, herbal remedy, vitamin and/or mineral supplements that may be taken by any route. If it is necessary that medication and/or treatment be provided during school hours, the following regulations must be followed:

1. A Medication and Treatment Consent Form must be signed by the parent/guardian and the physician. A Medication and Treatment Consent form can be obtained by contacting the school nurse.

2. Any changes in medication dose, route, schedule or discontinuation of medication must be communicated to the school nurse and a new Medication/Treatment Consent Form must be completed.
3. Medication must be brought to school in the original pharmacy container with the original label. Label must include the name of the student, the name of the medication, the name of the prescriber, the dose, time to be given, route and expiration date.
4. Medical treatment supplies shall be provided for school use for each student by Parent/Guardian as needed.
5. Medication must be picked up within three (3) days after the end of the school year or it shall be discarded.
6. Medication/Treatment Consent Forms must be renewed annually.

What if my child needs a medical procedure to be completed during the school day?

Parent(s)/Guardian(s) are urged to give medication and provide medical treatment at home and on a schedule other than school hours if possible. Medication includes prescription and non-prescription medication, homeopathic remedy, herbal remedy, vitamin and/or mineral supplements that may be taken by any route. If it is necessary that medication and/or treatment be provided during school hours, the following regulations must be followed:

1. A Medication and Treatment Consent Form must be signed by the parent/guardian and the physician. A Medication and Treatment Consent form can be obtained by contacting the school nurse.
2. Any changes in medication dose, route, schedule or discontinuation of medication must be communicated to the school nurse and a new Medication/Treatment Consent Form must be completed.
3. Medication must be brought to school in the original pharmacy container with the original label. Label must include the name of the student, the name of the medication, the name of the prescriber, the dose, time to be given, route and expiration date.
4. Medical treatment supplies shall be provided for school use for each student by Parent/Guardian as needed.
5. Medication must be picked up within three (3) days after the end of the school year or it shall be discarded.

Medication/Treatment Consent Forms must be renewed annually.

Can my child administer their own medications at school?

Self-administration/possession of medication is allowed in compliance with the rules of the GRPS medication policy. Students may be allowed to carry inhalers, Epi-Pens, insulin, and glucagon, if they comply with the rules of the policy.

Contact your school nurse to discuss if you would like more information.

What if my child has a life-threatening allergic reaction while at school?

Each of our schools are provided an emergency use Epi-Pen and Epi-Pen Jr. Our school nurses, school health aides, and Medical Emergency Response Team (MERT) members are trained in the administration of emergency epinephrine.

In the event that your child encounters a life-threatening allergen, and Epi-pen may be used, EMS will be activated, and you will be notified.

What if my child has a medical emergency while at school?

According to GRPS Medical Emergencies policy, maintaining a safe and injury-free environment is of primary importance to the Board of Education. In the event of a medical emergency, District staff will secure appropriate medical assistance for all students of the Grand Rapids Public Schools while in school or engaged in sanctioned school activities.

Will my child's medical information be kept confidential?

Yes. Our school nurses and district staff are required by federal privacy laws (FERPA) to protect your child's educational records, which include medical information provided to the school. Parent consent will be obtained prior to sharing this information with a third party.

Contact Us

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