

**Whitmore Lake Public Schools
Administration of Medication by School Personnel**

Michigan law requires a physician's written order along with the parent/guardian signature of authorization for administration of all prescribed medications. A parent/guardian signature of authorization and confirmation of medication appropriateness by a licensed physician is required for all non-prescription medications.

Authorization Form

Signature of physician and parent/guardian required for ALL prescribed medications.

Signature of parent/guardian and confirmation by a licensed physician required for ALL Over the Counter (OTC) medications.

Student Name: _____ Birthdate: _____ Teacher: _____ Grade: _____ School Year: _____

	Medication Name	Dose	Time given	Form/route*	Side Effects	Adverse Reactions	Self-administer Y or N
1							
2							
3							

*Routes – oral (pill/capsule/chewable/liquid) – inhaled (nebulizer/inhaler) – topical skin application – topical drops (eye/ear/nose) – injection – other (list)

List minimal frequency between doses (especially if prn): _____ If prn list symptoms/conditions under which medication is to be given: _____

Special instructions: _____

Start date (if not beginning of school year): _____ Stop date (if not the end of school year): _____

Physician's Signature _____ Date _____ Physician's Printed Name _____

Physician Phone # _____ Fax # _____ Address _____

Authorization of Parent/Guardian Concerning the Administration of All Above Medications by School Personnel

1. No prescription medications will be given without a physician's order, signed by the physician.
2. All prescription bottles must be labeled by the pharmacy with a current date, the name of the student, name and strength of the medication, dosage and frequency of administration.
3. Over the Counter medications must be contained in a labeled, original container.
4. The medication in any bottle must be the same medication as stated on the label.
5. No Over the Counter medication will be given without a parent/guardian signature and confirmation by a licensed physician.
6. Any change in prescription medication including a change in dosage or the discontinuation of the medication must be accompanied by a physician's order.

I hereby permit a School Nurse or other person designated by the Superintendent to administer medications as directed by the physician and/or myself to the above named student and will not hold the Board of Education or it's personnel responsible for the complications related to the medication pursuant to P.A. 451 of 1976 –S1178.

Parent Signature _____ Date _____