Medication Administration Authorization

School District: **Athens** School: **Athens Jr/ Sr High School** Fax**: (269) 729-9616**

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Michigan State Law (PA 51 of 2002) requires a written medication order by a physician and parent/guardian written authorization for designated individuals to administer medication to pupils at school. Medications must be in the original container, labeled with student's name, name of medication, amount and frequency to be given. This form is required for both prescription and Over-the-Counter (OTC) medications to be administered during school hours. The school provides no medications for students.

- Medication Must be delivered to school office by a Parent (Students are Not Allowed to Bring in medication)
- A Separate Authorization Form Must be Completed for Each Medication
- Parent Assumes Responsibility to Inform the Office of Any Change in Medication

PRESCRIBER'S AUTHORIZATION

Name of Student: ____________________ **Date of Birth:** ____________ **Grade:**__________

Address: ____

Condition for which drug is being administered: ____________________________

Name and Generic name of Drug: ____________________ **Dose:** ____________ **Route:** ____________

Time of Administration: ☐ **Lunchtime** ☐ **Other. Specify**____________ **If "As Needed," frequency:** ____________

Relevant side effects: ☐ None expected ☐ Specify: ____________________________

ALLERGIES: ☐ NO ☐YES (specify): ____________________________

Medication shall be administered from: ____________________ **to** ____________________
(Month / Day / Year) (Month / Day / Year)

Students may carry and self-administer medications such as inhalers for asthma, Epi-Pens for medically-diagnosed allergies, and insulin for diabetes with the written authorization of an authorized prescriber and written authorization from student's parent or guardian. All other medications (prescription and OTC) must be kept in the school office.

Prescriber's authorization for student to carry and self-administer: **Yes** **No** **N/A**

Prescriber's Name/Title: ____
(Type or print)

Telephone: ______________________ Fax: ______________________

Address: ____

Prescriber's Signature: ______________________ **Date:** ______________

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel and I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of this medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian authorization for student to carry and self-administer*:* **Yes** **No** **N/A**

Parent/Guardian Signature: ______________________ **Date:** ______________

Parent's Home Phone #: ______________ Cell # ______________ Work # ______________

School nurse approval for student to carry and self-administer**:** **Yes** **No** **N/A**

School Nurse Signature: ______________________ Date: ______________

Form Revised 10/18 MV