Medication Administration Authorization

School District: **Athens** School: **East Leroy Elementary** Fax: **(269) 729-9648**

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