Calhoun County Public Health Department School Wellness Program

Medication Administration Authorization

School District: _____ School: _____ Fax: _____

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 properly labeled container and dispensed by a physician/pharmacist.

- 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 self-administer medication such as inhalers for asthma, cartridge injectors for medically-diagnosed allergies, and insulin for diabetes. Some school policies (high school) also allow students to carry non-prescription medication such as non-narcotic analgesics for pain or cramps or antacid tablets such as Tums and prescription medications such as antibiotics for self-administration with the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: Yes No

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 I must supply the school with no more than a three (3) month supply of 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 self-administration**: Yes No*

Parent/Guardian Signature: _____ Date: _____

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

School nurse approval for self-administration: Yes No

School Nurse Signature: _____ Date: _____

Medadminform 4/15