PERMISSION FORM FOR PRESCRIPTION MEDICATION

Attached to this you will find the form for "Prescription" medications.

The administration of medication to students during the school day is regulated by state law. School personnel, as restricted by the State of Michigan, are not allowed to administer **ANY** medication unless it is under a doctor's order. When a student is in need of medication during the school day, the following procedure will be strictly adhered to.

Please do not ask school personnel for exceptions to these rules.

1. Medication must be accompanied by a doctor's written order and written authorization of the parent or guardian.
2. The permission form must be on file before any medication can be dispensed.
3. The medication must be in the original container. The student's name, the physician's name, current date, the name and strength of the medication, and the specific directions as to the administration of the medication must appear on the original pharmacy label on the container. The office staff cannot split pills that are in the container.
4. All medications must be delivered directly to the school office by a parent or guardian.
5. Liquid medications must be in a pre-measured form for each dosage that will be administered.
6. A log for each prescribed medication shall be maintained which will note the personnel giving the medication, the date, and the time of day. This log will be maintained along with the physician's written instructions and the parents signed release.
7. No more than a one-month supply will be stored in the buildings.
8. Any unused medication unclaimed by the parent will be destroyed by school personnel when a prescription is no longer to be administered at the end of the school year.

   Under no circumstances are children to transport any medication to or from school on the bus.

Algonac Community Schools

PERMISSION FORM FOR MEDICATION

School _____ Date received by school _____

Student _____ D.O.B. _____ Age _____

Grade ____ Teacher/Classroom _____ Principal's Signature _____

To be completed by physician or authorized prescriber:

Name of medication _____

Reason for medication (optional) _____

Form of medication/treatment: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler

☐ Injection ☐ Nebulizer ☐ Other _____

Dosage _____ Time(s) _____ _____ _____

Start: ☐ Date form received Other dates _____

Stop: ☐ End of school year Other date/duration _____

☐ For episodic/emergency events only Please explain _____

Restrictions and/or important side effects _____

_____ ☐ None anticipated

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

This student is both capable and responsible for self-administering this medication

☐ No ☐ Yes (Supervised) ☐ Yes (Unsupervised)

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information ☐ On the backside of this form ☐ As an attachment

Physician's Signature _____ Date _____

Physician's Name _____

Address _____ Phone _____

To be completed by parent/guardian:

☐ I request that (name of child) _____ receive the above medication at school according to district policy.

☐ I request that (name of child) _____ be allowed to self-administer the above medication at school according to district policy.

_____ _____ _____

Parent/Guardian Signature Date Relationship

White: Office Copy Yellow: Parent Copy Pink: Physician Copy

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