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 medical provider 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 medical provider/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.

Medical Provider/Prescriber Authorization

Name of Student: _____ **Date of Birth:** _____ **Grade:** _____

Address: _____

Condition for which drug is being administered: _____

Name and Generic Name of Drug: _____ **Frequency:** _____

Dose: _____ **Time of Administration:** ❒ **Lunchtime** ❒ **Other – Specify:** _____

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.

Medical Provider/Prescriber's authorization for self-administration: ❒ **Yes** ❒ **No**

Medical Provider/Prescriber's Name/Title: _____
(Type or Print)

Telephone: _____ Fax: _____

Address: _____

Medical Provider/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 Phone Number: Home: _____ Cell: _____ Work: _____

School Nurse approval for self-administration: ❒ **Yes** ❒ **No**

School Nurse Signature: _____ **Date:** _____