



## 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 PRN, frequency: \_\_\_\_\_

Relevant side effects:  None expected  Specify: \_\_\_\_\_

ALLERGIES:  NO  YES (specify): \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
(Month / Day / Year) (Month / Day / Year)

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse 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 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Home Phone #: \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

### SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

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 \_\_\_\_\_  
Signature Date

Parent/Guardian authorization for self-administration: Yes \_\_\_\_\_ No \_\_\_\_\_  
Signature Date

School nurse approval for self-administration: Yes \_\_\_\_\_ No \_\_\_\_\_  
Signature Date