# REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

Dear Parent/Guardian:

Under certain conditions, as a service to you and for the welfare of your child, parental requests for the in-school administration of necessary prescribed and/or over-the-counter medication/health procedures will be honored. This request is filled out individually for each medication required to be given during school hours and renewed at least annually. This parental request also gives the school permission to contact the prescribing provider as necessary. Please note: “Medication” refers to any prescription, non-prescription, homeopathic, herbal, vitamin, or mineral preparation.

Medications MUST:

- Be in original pharmacy container
- Brought to school by parent/guardian, other responsible adult, or the pharmacy

Medications MUST have a label showing the following:

- Students name
- Name of medication
- Dosage
- Frequency
- Doctor's name
- Pharmacy name
- Date Issued
- Prescription Number
- Expiration date

The written statement below, signed and dated by the attending physician, supporting this signed parental request is required prior to medication being given. The physician’s statement must also provide clear direction for administering the medication or health procedure in school. If the medication must be given at a certain time per the physician orders, the staff has a 30 minute window before and after the ordered time to administer the medication.

# REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

## PARENT SECTION

Student Name : ______________________

Student Grade : ______________________ Student Date Of Birth : ______________________

Parent/Guardian First/Last Name : ______________________

Address : ______________________

City/State/Zip : ______________________ Telephone : ______________________

Parent E-Mail : ______________________

Parent/Guardian Signature : ______________________ Date : ______________________

## PHYSICIAN SECTION

I recommend that the prescribed or over-the-counter medication/health procedure listed below be administered to:

Student Name : ______________________ Student Date Of Birth : ______________________

Diagnosis : ______________________

Name of Medication/Health Procedure : ______________________

Dosage : ______________________ Time Frequency: ______________________

Route of Administration : ______________________

Medication shall be administered from... : ______________________ to ______________________
Month / Day / Year Month / Day / Year

Side effects? If yes, specify : ______________________

Physician Name/Title : ______________________

Address : ______________________

Telephone / FAX : ______________________

Physician Signature : ______________________ Date ______________________

(Imprint Physician's Office Stamp)

*Attach any additional instructions or notes to this form

35100 Little Mack Avenue, Clinton Twp, MI, 48035
(586) 791-6300 ext. 3001
clintondaleschools.net

# SELF CARRY/SELF ADMINISTRATION OF MEDICATION AUTHORIZATION APPROVAL

- Self carry/self administration of medication (including emergency medication) may be authorized by the physician and must be approved by the school nurse in accordance with the Administration of Medication policy. The parental or guardian request/permission and physician's instructions must be renewed annually, or more often if necessary.
- It must be determined by the school nurse whether a student who self-administers medication is responsible to self-carry their medication. The developmental ability of the student, the need to have ready access to emergency medication, and the safe storage of medication must be taken into account when making this decision.

PARENT/ GUARDIAN authorization for self carry/self administration of medication :

Signature Date

PHYSICIAN authorization for self carry/self administration of medication :

Signature Date

SCHOOL RN approval for self carry/self administration of medication :

Signature Date

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