WISD Administration of Medication by School Personnel Form

Name of Student: _____Date of Birth: _____ School/classroom:_____

Washtenaw Intermediate School District Medication Administration Policy requires a written prescription from a student's physician/authorized prescriber accompanied by the written authorization of the student's parent/guardian for medication to be given at school.

Medication authorization and instructions to be completed by the physician/authorized prescriber on **all medications (including non-prescription)** to be given at school:

Medication Name	**1.**	**2.**	**3.**	**4.**
Dose of Medication				
Time(s) of Administration				
Route of Administration				
Adverse reactions (Side Effects)				
Special Comments (including when to give PRN medications)				

***Physician and Parent (both needed)-Please check any boxes that apply to this student:** **Physician** **Parent**

1. Student is both capable and responsible for self-administering this medication ……. ☐ ☐
2. Supervision is needed for student to self-administer this medication…….. ☐ ☐
3. Student may carry this medication…….. ☐ ☐

Physician's Signature _____Date:_____ Physician's Printed Name _____

Address: _____ Phone: _____

Authorization of Parent/Guardian for the Administration of Above Medications by School Personnel

1. Medication will not be given unless a physician's order including the physician signature and a parent /guardian's signature are provided according to the district's Medication Administration policy.
2. All prescription containers must be labeled by the pharmacy with a current date, name of the student, name and strength of the medication, dosage, route and frequency of administration.
3. Over-the-counter medications must be in the labeled, original container.
4. Any changes in medication, including a change in dosage or discontinuation of the medication, must be accompanied by a physician's order.
5. The "Administration of Medication by School Personnel Form" must be updated every school year.

I, as parent/ guardian of the above-named student, hereby request that school personnel, designated by the District Superintendent, administer the medications listed on this form as directed by the physician. I will not hold the Board of Education or it's personnel responsible for any complications related to the medication pursuant to P. A. 451 of 1976-S1178.

Parent/Guardian Signature_____ Date _____