Administering Medicine to Students

Dear Parents and Physician:

It is the policy of the Clarenceville School District, in compliance with Michigan Compiled Laws Section 380.1178, to have written authorization for a student to take prescribed medication during the school day. This information will be handled in a confidential manner. **Authorization is good for one school year only**.

Student Name: _____ **Grade:** _____

Date of Birth: _____ **School:** _____

Medication	Dose	Time to be Given	Route*	Side Effects	Self-Administration Authorization	
1.					**Yes** ☐	**No** ☐
2.					**Yes** ☐	**No** ☐
3.					**Yes** ☐	**No** ☐

*Routes: ***Oral** (pill, capsule, chewable, liquid) ***Topical** (skin, eye drop, ear drop, cream/ointment) ***Inhaled** (inhaler, nebulizer)

To be completed by Physician:

Physician's Name: _____
(please print)

Phone Number: _____ **Fax Number:** _____

Physician's Signature: _____ **Date:** _____

To be completed by Student:

I AGREE TO:

1. Never share, sell, or distribute my medication with another person.
2. Carry the medication in its original, properly labeled prescriptive/over the counter container.
3. Take medication only at the prescribed time/frequency and dose.

I am knowledgeable regarding the dose, desired effects, side effects, and administration of the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parent/guardian and privilege(s) of self-administration/self-possession denied.

Student Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

District Staff Signature: _____ **Date:** _____