SOUTH LYON COMMUNITY SCHOOLS

Permission Form for Prescribed and/or Non-Prescribed Medication

Student:	Date of Birth:	☐ Male ☐ Female Grade
Home Phone Number:	Parent/Guardian Work Phone:	
Date form received by school:		

To be completed by the Physician or Authorized Prescriber

Name of medication:	Dosage:
Form of medication ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other	
Reason for medication (optional):	
Time medication to be administered during school hours:	Dose:
Start medication: ☐ Date form received ☐ Other date (specify)	
Stop medication: ☐ End of school year ☐ Other date (specify)	
☐ For episodic/emergency use only Special Instructions:	
Restrictions and/or possible side effects:	
Storage Requirements: ☐ None ☐ Refrigerate ☐ Other:	
This student is both capable and responsible for self-administering this medication: ☐ No ☐ Yes – Supervised ☐ Yes - Unsupervised	
Are there extenuating circumstances which make it necessary for the student to self-possess and self-administer this medication? ** MUST COMPLETE OPTION 3 BELOW **	
The student may carry this medication. If yes, parent must fill out Option 2 or Option 3 below. ☐ Yes ☐ No	
PLEASE NOTE: NARCOTICS AND CONTROLLED SUBSTANCES SUCH AS RITALIN MUST BE DISPENSED THROUGH SCHOOL OFFICE.	
Please indicate if you have provided additional information: ☐ On the back of this form ☐ As attachment	
Physician/authorized prescriber signature or stamp only: _____ Date: _____	
Address: _____ Phone: _____	

To be completed by parent/guardian (*Choose one of the options below)*

OPTION 1

I request that _____ receive the above medication in the school office according to South Lyon Community Schools Administration of Medication Policy.

Parent/Guardian Signature: _____ Relationship: _____

Date: _____

OPTION 2 (self-possess)

Our physician has indicated that there are extenuating circumstances which make it necessary for _____

To self-possess and/or transport this medication. However, it is necessary for _____ to receive the above medication by school personnel according to the South Lyon Community Schools Administration of Mediation Policy.

Parent/Guardian Signature :_____ Relationship: _____

Date: _____

OPTION 3 (self-possess & self-administer)

Our physician has indicated that there are extenuating circumstances which make it necessary for _____

to self-possess and self-administer this medication. Therefore, I request that the building administrator approved this request and allow my child to self-possess and self-administer the above medication at school according to the South Lyon Community Schools Administration of Medication Policy , and I agree that the Procedures for Self-Possession and Self-Administration found in that policy will be followed. Parent/Guardian Signature: _____ Relationship: _____

Student Signature: _____ Date: _____

Building Administrator Signature: _____ Date: _____

PRACTICE/PROCEDURES FOR
MEDICATION DISPENSED DURING SCHOOL

We recognize some students are able to able to attend regular school because of the effective use of medication in the treatment of chronic disability or illness. We are also aware some prescriptions require that medication be given while the individual is in attendance at school. The following procedure will be followed in order to protect the student and the adult administering the medication:

1. Written directions from the physician must detail the names of the drug, dosage, and the time interval medication is to be taken. Directions must be renewed annually. Authorization forms may be obtained in the building office or on the South Lyon Community Schools web-site.
2. Written permission from the parent/guardian requesting that the school district comply with the physician's order must be submitted with the physician's written directions. An appropriate form is available in the building office or on the South Lyon Community Schools web-site.
3. MEDICATION MUST BE BROUGHT TO THE SCHOOL IN THE ORIGINAL CONTAINER LABELED BY THE PHARMACY OR PHYSICIAN.
4. No more than a forty-day supply of medication should be received from home. This will be stored in a locked cabinet and dispensed under the supervision of building personnel.
5. No medication will be kept for more than once school year. At the end of the school year, if the medication is not picked up by a parent/guardian, it will be destroyed.
6. If an elementary aged student requires administration of a non-prescription medication (i.e. aspirin, Tylenol, etc), a parent/guardian must submit written directions from a doctor (including name of medication, dosage, and time interval) AND permission to administer. Appropriate forms are available in the building office. Forms must be renewed annually. MEDICIATION MUST BE BROUGHT TO THE SCHOOL BY PARENTS.
7. If a middle school aged student requires administration of a non-prescription medication (i.e. aspirin, Tylenol, etc), the parent/guardian must submit written authorization giving student permission to self-administer. Authorization must include name of medication, dosage, and time interval.
8. If an high school aged student requires administration of a non-prescription medication (i.e. aspirin, Tylenol, etc), no written authorization is required.
9. A written record of the administration of medication will be maintained in the building office.