

Permission Form for Prescribed and/or Non-Prescribed Medication

Forms must be dated on or after July 1st of the school year in which the medication will be taken.

Student: _____ Date of Birth: _____
 Male Female Grade _____
 Home Phone Number _____ Parent/Guardian work phone number _____
 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?
 Yes No
 The student may carry this medication. If yes, parent must fill out Option 2. Yes No
PLEASE NOTE: NARCOTICS AND CONTROLLED SUBSTANCES SUCH AS RITALIN MUST BE DISPENSED THROUGH THE SCHOOL OFFICE.
 Please indicate if you have provided additional information: On the back of this form As an attachment
 Physician/authorized prescriber signature: _____ Date _____
 Address: _____ Phone Number: _____

To be completed by parent/guardian PARENT MAY PICK MORE THAN ONE OPTION

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 have the medication administered by school personnel according to the South Lyon Community Schools Administration of Medication 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 approve 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 that some students are 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 procedures 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 one 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. **MEDICATION 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 a 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.