Huron Valley Schools – Plan of Care (POC)
Administering Medicine(s) to Students

Bus Route _____

Student Name: _____ School: _____ Grade: _____

Dear Parents and Physician:

It is the policy of Huron Valley Schools, 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 valid for one school year only.**

MEDICATION NEEDS TO BE IN ITS ORIGINAL CONTAINER

Student Date of Birth: _____

Check one (1):

☐ Authorization is hereby granted for school personnel to administer medication to the above named student, in accordance with the following physician's directive

☐ I request that the above named student be allowed to carry/self-administer medication at the school according to school policy in pursuant to the physician's approval.

1. Name of Medication: _____ Dosage: _____

Reason for medication: _____

To be given at: _____ (time/hour)

Date Range: _____ to _____

Comments regarding medication (adverse reactions, precautions, special instructions, etc.):

This student is both capable and responsible for carrying this medication ☐ Yes ☐ No

This student may carry this medication ☐ Yes ☐ No

2. Name of Medication: _____ Dosage: _____

Reason for medication: _____

To be given at: _____ (time/hour)

Date Range: _____ to _____

Comments regarding medication (adverse reactions, precautions, special instructions, etc.):

This student is both capable and responsible for carrying this medication ☐ Yes ☐ No

This student may carry this medication ☐ Yes ☐ No

In case of emergency, contact: _____Phone_____

_____ / _____ _____ /_____

PARENT SIGNATURE DATE PHYSICIAN SIGNATURE DATE

Physician Name _____

Physician Address _____

Physician Phone _____