

**WEST BLOOMFIELD SCHOOL DISTRICT**  
**Permission Form for Prescribed or Over the Counter Medication**  
**Including Self-Administration and Self-Possession of Medications**

**ELEMENTARY**  
**And**  
**SECONDARY**

**Dear Parents and Physician:**

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

**Student** \_\_\_\_\_ **School** \_\_\_\_\_  
Date of birth, or age: \_\_\_\_\_ Date form received by the school: \_\_\_\_\_  
Grade \_\_\_\_\_  
Administrator approval for self-administration  self-possession   
Administrator signature \_\_\_\_\_ Date \_\_\_\_\_

**To be completed by the physician or authorized prescriber**

Name of medication: \_\_\_\_\_  
Reason for medication: (OPTIONAL) \_\_\_\_\_  
Form of medication/treatment:  Tablet/capsule  Liquid  Inhaler  Injection  
 Nebulizer  Other \_\_\_\_\_  
Instructions (schedule and dose to be given at school): \_\_\_\_\_  
\_\_\_\_\_  
Start:  date form received Other dates: \_\_\_\_\_  
Stop:  end of school year Other date/duration: \_\_\_\_\_  
 For episodic/emergency events only  
Restrictions and/or important side effects:  None anticipated  
 Yes. Please describe: \_\_\_\_\_  
Special Storage requirements:  None  Refrigerate  
Other \_\_\_\_\_

This student is both capable and responsible for self-administering this medication:  No  Yes-supervised  Yes-Unsupervised  
This student may carry this medication:  No  Yes  
Please indicate if you have provided additional information:  On the back of this form  As an attachment

**Physician's Signature** \_\_\_\_\_ **- Date** \_\_\_\_\_

<b>Physician's Name</b> _____
<b>Address</b> _____
<b>Phone Number (____)</b> _____ <b>Fax Number</b> _____

**To be completed by parent/guardian**

I request that \_\_\_\_\_ receive the above medication at school according to standard school policy.  
Name of child \_\_\_\_\_

I request that \_\_\_\_\_ be allowed to self-administer the above medication at school according to the school policy. \*

Name of child \_\_\_\_\_

I request that \_\_\_\_\_ be allowed to self-possess the above medication at school according to school policy. \*

Name of child \_\_\_\_\_

\* NOTE: Elementary students must have an active IEP or Section 504 Plan to self-administer and self-possess medication.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_