NOVI COMMUNITY SCHOOL DISTRICT
Request for Permission to
SELF-ADMINISTER/POSSESS MEDICATION

*It is the policy of the Novi Community School District to require a completed authorization form when requesting that a student be allowed to consume or apply prescription and/or non-prescription medication in the manner directed by a physician without additional assistance or direction from school personnel during school hours or for the purpose of school field trips***.**

Student name: _____ **Grade:** _____
(please print)

Birth date: _____ **School:** _____

Medication	Dose	Time to be Given	Route*	Side effects
1.				
2.				
3.				

*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 Nurse Signature _____ **Date** _____