Novi Community School District
Medication Authorization Form

Insert Photo with authorization from parent/guardian only.

This form SHOULD NOT be used for Asthma, Allergies or Seizures.
Please use the appropriate plan form for those medical issues

Student Name: _____ Birth Date: _____

Teacher:_____Grade: _____

School Year:_____Parent/Guardian Cell phone #:_____

To be completed by Physician/Licensed Personnel Only:

All/Any prescription or over-the-counter medications must be signed by physician/licensed prescriber:

	Medication	Dose	Time to be given	Form/Route*	Side Effects
1.					
2.					
3.					

*Routes **Oral** (pill, capsule, chewable, liquid) **Topical** (Skin, eye drop, ear drop, cream, ointment)
Inhaled (inhaler, nebulizer) **Other** (List)

Reason for medication: Medication #1_____

Medication #2_____

Medication #3_____

Special Instructions: _____

Does Medication need to be available on bus? ☐YES ☐NO _____Verified by District Nurse

Start date if not beginning of school year: _____End date if not end of school year_____

_____ _____ _____

Physician's Signature Physician's printed name Date

Physician's phone#: _____ FAX#: _____

Address: _____

To be completed by Parent/Guardian:

I request and give permission for the above child listed to receive the above medication(s)/treatment at school according to standard school district policy and for the physician or physician's staff and school district staff to share information needed to assist my child with medication needs. Schools require parent/guardian to bring medication in its original container (no exceptions will be made if not in original container). All medication must be labeled with the student's name and must be current.

_____ _____

Parent/Guardian signature Date

Students with health/medical issues may be eligible for protection under Section 504, a federal disability law. Parents who wish to initiate a request for a 504 evaluation should contact the office of the student's counselor or building principal.

Revised 12/19 ja Form Reviewed District Nurse_____