WYANDOTTE PUBLIC SCHOOLS

Medication/Medical Procedure Physician/Parent Authorization

Michigan law requires a physician's written order and parent/guardian authorization for administration of medication/medical procedures to be done in school

Name:_____ Birthdate:_____ School Year:_____

To be completed by physician/licensed prescriber:

Medication Name	Dose	Time Given	Route/Form	Reason Given
Special Treatments: (t-feedings, 02, suction, cath, etc.)				

PRN meds – list minimal frequency between doses and conditions under which medication is to be given:

_____

_____

Special Instructions and/or important side effects: _____

_____

Physician's Signature:_____ Physician's printed name:_____ Date:_____
Physician's phone and fax number:_____
Physician NPI number_____
Physician's address:_____

To be completed by parent/guardian:

I request and give permission for my child to receive the above medications/treatment at school in accordance with district policy, and for physician's staff and school district staff to share information as needed to assist my child with his/her medical needs. The medication and/or supplies will be provided by me to the school district in accordance with school district policy.

Parent/Guardian Signature:_____ Date:_____

Home Phone:_____ Cell Phone_____ Work Phone _____