Date Received: _____

TROY SCHOOL DISTRICT
AUTHORIZATION FOR MEDICATION/TREATMENT

It is the policy of the Troy School District to have written authorization for a student to take any medication during the school day.

Student Name: _____ Grade: _____ Date of Birth: _____

To be completed by the Physician or Authorized Prescriber:

Name of medication: _____

Reason for medication *(optional)*: _____

Form of medication/treatment:

❒ Tablet/capsule ❒ Liquid ❒ Inhaler ❒ Nebulizer ❒ Injection ❒ Glucometer ❒ Other: _____

Instructions (schedule and dose to be taken at school):

_____

Route of Medication (Oral, etc.): _____

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 may carry an inhaler ***(applicable to all students)***: ❒ No ❒ Yes

This student may carry an EpiPen ***(applicable to all students)***: ❒ No ❒ Yes

This student may carry this medication ***(applicable to high school students, with the exception of inhalers and EpiPens)***: ❒ No ❒ Yes

This student is both capable and responsible for self-administering this medication ***(applicable to high school students only, with the exception of inhalers and EpiPens)***: ❒ No ❒ Yes—supervised ❒ Yes—unsupervised

Signature: _____ Date: _____ Phone #: _____

Physician's Name: _____ Address: _____

To Be Completed by Parent/Guardian:

I request that *(check appropriate direction below)*:

❒ School personnel store and administer the medication to the above-named student as prescribed, which shall be done in the presence of another adult, except in emergencies.

❒ School personnel and/or clinic volunteer store the medication only. The above-named student shall be responsible for self-administering the medication without supervision or monitoring by school personnel ***(applicable to high school students only, with the exception of inhalers and EpiPens)***.

❒ The above-named student be allowed to carry and self-administer nonprescription medication without the supervision or monitoring by school personnel ***(only applicable to high school students only)***.

I understand and agree that all medication must be in the original container, clearly marked with the student's name, name of medication, and prescribed dosage.

Parent/Guardian Name: _____ Relationship: _____

Signature: _____ Date: _____

Procedures on reverse side

Troy School District
Medication Procedures

1. Medications must be brought to school by the student's parent or legal guardian.

2. All medications must be in a container as prepared by a pharmacy, physician, or pharmaceutical company and clearly marked with the student's name, the name of the medication, the prescribed dosage, and requested time of administration.

3. All controlled-substance medications will be counted and recorded in the presence of the parent/legal guardian when brought to school.

4. Changes in dosage, frequency, or time of administration cannot be made without written instruction from a physician.

5. Designated staff will be administering medication.

6. Administrators, counselors, teachers, and other appropriate staff will be made aware of your child's condition and need for medication.

7. The school will NOT be distributing lunch or afternoon medications on half days of school.

8. Medication left over at the end of the school year or after a pupil has left the district shall be picked up by the parent/legal guardian. Any medication not retrieved by the parent/legal guardian will be disposed of within seven days of the last student day of school and documented by the individual who is responsible for administering medication.

9. Please list all medications your child is currently taking, whether taken in the home or at school (o*ptional*):

_____ _____

_____ _____

_____ _____

Parent Signature Date