

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, O2, 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 _____

