Bloomfield Hills Schools

Authorization for Non-Prescription Medication

Ideally, all medication should be given at home. School district personnel are not trained health care professionals. Parents and guardians have the primary responsibility for administering their child's medication; however, the school **may** cooperate with parents and guardians in administering non-prescription medication that is authorized by parents or guardians. Bloomfield Hills Schools requires written authorization for a student to take non-prescription medication during the school day. This form must be completed and returned to the principal before medication may be administered. This authorization form covers the non-prescription medication described below and is valid only for the dates indicated below.

Reminders:

- **All medication must be delivered in its original container (no baggies full of pills are to be carried to the school by the student).**
- **The original dose of medication must be given at home, not at school.**
- **School employees will not administer aspirin unless it is prescribed by a physician.**

This section is to be completed by the student's parent or legal guardian.

Student Name: _____

Parent/Legal Guardian Name(s): _____

Name of non-prescription medication: _____

Dosage: _____ Times: _____

For Period: _____ To: _____

(Date) (Date)

Date and time of first dose of medication: Date: _____ Time: _____

Emergency Contact #1: _____ Phone: _____

Emergency Contact #2: _____ Phone: _____

***High School Students Only**:* High school students may carry non-prescription medication to school and responsibly self-medicate provided this form is completed by the parent/legal guardian. I give my permission for my high school student to carry this medication on his/her person and self-administer the medication: Yes ☐ No ☐

I give my permission and authorization for this medication to be administered as prescribed above and for doing so, I hereby release from liability and agree to indemnify any personnel or volunteers of the school district for any action or inactions associated with the administration of medication to the above student.

Parent/Legal Guardian Signature: _____ Date: _____

Phone Number: Work: _____ Home: _____

Other Phone Numbers: _____

Discontinuation of Medication

At the time this medication is to be discontinued, the parent/guardian must sign and date this form and return to the school office. Please discontinue dispensing the medication described above for:

_____ as of _____

(Name of Student) (Date)

Parent/Legal Guardian Signature: _____ Date: _____

Fax is acceptable initially. Original must be received within two (2) school days.

Distribution: > School Office > Student Records > Parent/Legal Guardian

Pers. 7/04