Bloomfield Hills Schools

Authorization for 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 prescription medication that is authorized by parents or guardians. Bloomfield Hills Schools requires written authorization for a student to take prescription medication, including adrenalin (epinephrine) or inhalers, during the school day. This form must be completed and returned to the principal before medication may be administered. This authorization form covers the prescription medication described below and is valid only for the current school year. All medication must be delivered to school by a parent, guardian or an adult designated by the parent/guardian; delivered in the original container with labeling which includes the name of the student, physician, medication and prescription.

Epi-Pen/Inhalers: may be kept in the possession of the student if the parent/guardian and physician so indicate on this form. However, the parent/guardian is strongly encouraged to provide a second inhaler or epi-pen to be stored in the school office.

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

Student Name: _____

Parent/Legal Guardian Name(s): _____

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

High School Students Only: I give my permission for my high school student to carry this medication on his/her person and self-administer the medication: Yes ___ No ___

Emergency Contact #1: _____ Phone: _____

Emergency Contact #2: _____ Phone: _____

If an epi-pen or inhaler is prescribed, I authorize the epi-pen or inhaler to be carried by my child: Yes ☐ No ☐

This section to be completed by the student's physician.

Name of prescription medication: _____

Dosage: _____ Times: _____

For Period: _____ To: _____

(Date) (Date)

Reason for Medication (diagnosis and anticipated effects):

_____

Possible Symptoms:

_____

Possible Reactions: _____

Circumstances under which no medication is to be given:

_____

If an epi-pen or inhaler is prescribed, I authorize the epi-pen or inhaler to be carried by the student: Yes ___ No ___

Additional Comments:

_____

Physician Signature: _____ Date: _____

Address: _____ Phone: _____

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 parents or guardian must sign and date this form and return to the school office. Please discontinue dispensing the medication described above for:

_____ as of _____

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. 5/04