WEST BLOOMFIELD SCHOOL DISTRICT

Permission Form for Prescribed or Over the Counter Medication
Including Self-Administration and Self-Possession of Medications

ELEMENTARY And SECONDARY

Dear Parents and Physician:
It is the policy of the West Bloomfield School District, in compliance with Michigan Compiled Laws Section 380.1178, to have written authorization for a student to take prescribed or over the counter medication during the school day. This information will be handled in a confidential manner. Authorization is good for one school year only.

Student _____ **School**_____
Date of birth, or age: _____ Date form received by the school:_____
Grade _____
Administrator approval for self-administration ☐ self-possession ☐
Administrator signature_____Date _____

To be completed by the physician or authorized prescriber
Name of medication:_____
Reason for medication: (OPTIONAL)_____
Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection
☐ Nebulizer ☐ Other_____
Instructions (schedule and dose to be given at school):_____
_____
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 is both capable and responsible for self-administering this medication: ☐ No ☐ Yes-supervised ☐ Yes-Unsupervised
This student may carry this medication: ☐ No ☐ Yes
Please indicate if you have provided additional information: ☐ On the back of this form ☐ As an attachment

Physician's Signature_____- Date_____

Physician's Name_____
Address_____
_____
Phone Number (___)_____Fax Number_____

To be completed by parent/guardian

I request that _____receive the above medication at school according to standard school policy.
Name of child

I request that_____be allowed to self-administer the above medication at school according to the school policy. *
Name of child

I request that _____be allowed to self-possess the above medication at school according to school policy. *
Name of child

* NOTE: Elementary students must have an active IEP or Section 504 Plan to self-administer and self-possess medication.

Date:_____ Signature:_____ Relationship:_____

8/05