Student Name: _____

Grade: _____

LIVONIA PUBLIC SCHOOLS 15125 FARMINGTON ROAD, LIVONIA, MI 48154

MEDICATION AUTHORIZATION

STUDENT'S NAME	DATE OF BIRTH	TODAY'S DATE
SCHOOL	TEACHER/COUNSELOR	GRADE

Both prescription and nonprescription medications require a completed Medication Authorization form signed by a physician and parent/guardian. If medication is related to a life-threatening health condition, Livonia Public Schools staff will develop an Individualized Health Care Plan in conjunction with the student's physician.

TO BE COMPLETED BY THE PHYSICIAN:

NAME OF MEDICATION:	☐ Prescription ☐ Non-Prescription
REASON FOR MEDICATION:	
FORM OF TREATMENT: ☐ Tablet/Capsule ☐ Inhaler ☐ Liquid ☐ Injection ☐ Nebulizer	
INSTRUCTIONS:	
DOSAGE:	TIME OF DAY: ☐ Daily ☐ As Needed ☐ Emergency Only ☐ Other
IF DOSAGE IS "AS NEEDED" OR "EMERGENCY ONLY" SPECIFY SYMPTOMS AND LIMITS:	
RELEVANT SIDE EFFECTS:	
STORAGE REQUIREMENTS: ☐ None ☐ Refrigerate ☐ Other	STUDENT IS CAPABLE AND RESPONSIBLE FOR SELF-POSSESSION AND SELF-ADMINISTERING: ☐ Inhaler ☐ Emergency
PLEASE INDICATE IF YOU HAVE PROVIDED ADDITIONAL INFORMATION: ☐ On the back of this form ☐ As an attachment	

PHYSICIAN'S NAME:	PHONE:	FAX:
ADDRESS:		
PHYSICIAN'S SIGNATURE:		DATE:

TO BE COMPLETED BY THE PARENT/GUARDIAN

I request that _____ Receive the above Medication at school according to district policy.
Student's Name Be allowed to self-administer the above medication (Inhaler or emergency medication) at school according to district policy.

I authorize school personnel to contact the above physician with questions or concerns relative to this authorization and medication.

_____ _____
Parent/Guardian's Signature Date

*NOTES:

1.) Medication includes prescription, non-prescription and herbal medications, and includes those taken by mouth, by inhaler, those that are injectable, and those applied as drops to eyes, nose, or medications applied to the skin.
2.) Medications must be in an appropriately labeled container.
3.) This authorization is valid for the current school year only.
4.) This authorization must be maintained with the Individual Student Medication Log.
5.) It will be the student's responsibility to make contact with school personnel for the administration of medication, unless other arrangements have been made by the administrator.

Revised 06/07