Riverview Community School District
Medication Administration Authorization Form

Michigan State Law requires that school staff administering medications must have written orders from the physician/licensed prescriber and written authorization from the parent/guardian**.**

PLEASE NOTE - "Medication" refers to any prescription, over-the-counter (OTC), homeopathic, herbal, vitamin, or mineral preparation

Parents are urged to give medication at home on a schedule outside of school hours, if possible. If it is necessary that medication be provided during school hours, these regulations must be followed:

- Medications must be prescribed in writing by a physician or other licensed prescriber and must be renewed at least annually.
- All medication must be brought to school in the original pharmacy or OTC container labeled with the name of the student, medication, strength, dosage, route, and time(s) to be given. The parent/guardian is expected to deliver the medication to the school. Students are not allowed to bring their own medication to school.
- Medications and related equipment/supplies, as ordered, must be provided to the school by parent/guardian as needed.
- A separate authorization form must be completed for each medication that will be administered throughout the school day.

STUDENT'S NAME: _____ **DATE OF BIRTH:** _____

SCHOOL: _____ **Teacher:** _____ **GRADE:** _____

TO BE COMPLETED BY THE PHYSICIAN:

Medication Name	Dosage	Route	Time & Frequency

Form of medication: ❑Tablet/capsule ❑Liquid ❑Inhaler ❑Injection ❑ Nebulizer ❑ Other _____

Special instructions/storage requirements: _____

Signs/Symptoms for which medication is being prescribed: _____

Restrictions and/or important side effects: _____

Order Start Date: _____ Order End Date: _____

(If no end date is indicated, medication orders will expire at the end of the current school year).

NOTE: To participate in Medicaid School Services Program, a valid prescription MUST be signed and dated by a physician or other licensed prescriber and include the prescriber's name, address, telephone number, and NPI number.
*Stamped signatures are **not** valid for school-based services.*

Signature: _____ Date: _____

Printed Name: _____ NPI #: _____

Address: _____

Phone: _____ Fax: _____

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby authorize trained school staff to administer the identified medication, ordered by the licensed prescriber, to the child named above. I will not hold the Board of Education or its personnel responsible for complications related to the medication pursuant to P.A. 451 of 1976-S1178. When necessary, staff may contact the licensed prescriber regarding administration of the medication. I understand that I am responsible for transporting the medication to the child's school.

Signature: _____ Relationship: _____ Date: _____

Please return completed form to: _____ ***Fax:*** _____ ***Email:*** _____