

MEDICATION ADMINISTRATION AUTHORIZATION

Marshall Public Schools
100 E. Green Street
Marshall, Michigan 49068
Phone: (269) 781-1251 Ext. 1160
Fax- MHS: (269) 781-5304 MOHS: (517) 630-3305 MMS: (269) 781-6621
Fax- Gordon: (269) 789-3700 Harrington: (517) 629-8209 Hughes: (269) 789-3704 Walters: (269) 789-3703

Student Name _____ Birth Date _____

Building _____ Grade _____ School Year: _____

Allergies _____ EPI-Pen Yes No Inhaler Yes No (List below if Yes):

***Please read all of the instructions below:**

- This form must be completed fully in order for schools to administer the required medication (prescribed and OTC).
- All Medication Administration Authorization (MAA) forms must have a medical provider & guardian signature to be valid.
- A new MAA form must be completed at the beginning of each school year & each time there is a change in dosage or time of administration.
- Prescription medication must be in an up-to-date container labeled by the pharmacist/prescriber & match the MAA.
- Non-prescription medication (OTC) must be in the original container with the label intact and provided by parents.
- An adult (18+) must bring the medication to school at the beginning of the school year, when refills are requested, & pick the medication up at the end of the school year. Minors cannot sign their own medication in & out of school.
- The District Nurse (RN) will call the prescriber if a question arises about the child and/or the child's medication.

Prescription/Non-Prescription (OTC) Medication Name:	Dose:	Time(s) to be given at School (Please circle or write time):	Side Effects/Special Instructions (Please List):
		Breakfast Lunch PRN Other:	
		Breakfast Lunch PRN Other:	
		Breakfast Lunch PRN Other:	
		Breakfast Lunch PRN Other:	
		Breakfast Lunch PRN Other:	

Non-Prescription (OTC) Medication:

Trained Marshall Public School staff/designees may give the following medications (as available/needed) according to manufacturer instructions to the student named above during the school year (**Please circle all that can be given**):

Motrin(Ibuprofen) **Tylenol**(Acetaminophen) **Benadryl**(Diphenhydramine) **Tums**(Calcium Carbonate) **Cough Drop**(Lozenge)

The student named above is able to self carry/self administer their emergency medication. (Please circle one & sign below): YES / NO

**Self-carry/self-administration of emergency medication (including Epipens, Inhalers, Insulin, Glucagon, Valtoco) during school hours must be authorized by the prescriber, the parent/guardian, and must be approved by the district nurse according to the school's medication policy-otherwise all medications-including emergency- will be kept in the school health office during the school year.*

-Prescriber's approval for self-carry/self-administration of emergency medication: _____

Signature _____ Date _____

-Parent/Guardian's approval for self-carry/self-administration of emergency medication: _____

Signature _____ Date _____

-District Nurse's approval for self-carry/self-administration of emergency medication: _____

Signature _____ Date _____

***Trained Marshall Public School staff/designees have my permission to provide basic first aid and administer medications according to policy listed above. I understand that in case of illness or injury an attempt will be made to contact me at the telephone numbers listed on the emergency contact forms in PowerSchool, via ParentSquare, or written communication. I agree and consent to all the terms listed on this form for the current entire school year.**

PRINTED NAME OF PHYSICIAN/MEDICAL PROVIDER

DATE

SIGNATURE OF PHYSICIAN/MEDICAL PROVIDER

DATE

SIGNATURE OF PARENT/GUARDIAN

DATE