HASLETT
PUBLIC SCHOOLS

Physician Authorization for Prescription and Over the Counter Medications for Students at School

Student Information

Student Name: _____ Date of Birth: _____

Grade: _____ School: _____

Parent/Guardian Name: _____ Phone Number: _____

Section 1: Physician's Authorization for Medication Administration During School

To be completed by the student's licensed physician:

Medication Type (circle one): Prescription Over-the-Counter

Medication Name:_____

Dosage: _____ Administration Time(s): _____

Duration of Administration (e.g., school year, specific period): _____

Special Instructions (e.g., with food, avoid sunlight, etc.): _____

Section 2: Physician Information

Physician Name: _____ Office Phone Number: _____

I authorize the treatment mentioned above or medication necessary during school hours, which can be administered by designated school personnel as prescribed.

Physician's Signature: _____ Date: _____

Section 3: Parent/Guardian Authorization

I hereby permit the above treatment/medication to be administered to my child, and I understand that trained school personnel may administer it.

Parent/Guardian Signature: _____ Date: _____

Section 4: Self-Carry Authorization (Asthma Inhalers, EpiPens, or Other Emergency Medications)

If approved by the health care provider and parent/guardian, students may be allowed to carry and self-administer emergency medications (such as asthma inhalers or EpiPens) during school hours and at school-related activities.

Physician Authorization for Self-Carry:

I certify that the student mentioned earlier has been instructed in the proper use of the medication and can carry and self-administer it responsibly.

Is the student approved to self-carry this medication? ☐ Yes ☐ No

Physician's Signature: _____ Date: _____

Parent/Guardian Authorization for Self-Carry:

I give my consent for the student mentioned earlier to self-carry and self-administer the prescribed medication as needed. I understand that the school is not responsible for ensuring that the student takes the medication as prescribed.

Parent/Guardian Signature: _____ Date: _____