

TROY SCHOOL DISTRICT AUTHORIZATION FOR MEDICATION AND/OR TREATMENT

It is the policy of the Troy School District to have written authorization for a student to take any medication during the school day.

To be completed by the Physician or Authorized Prescriber: ONE MEDICATION PER FORM

Name of Medication:

Reason for Medication:

For of Medication / Treatment:

- Tablet / Capsule
 Liquid
 Inhaler

- Nebulizer
 Injection
 Glucometer

Other:

Instructions (SCHEDULE and DOSE to be taken at school):

Route of Medication (Oral, etc.)

- Start: Date from 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 may carry an inhaler (applicable to all students):

- Yes No

This student may carry an EpiPen (applicable to all students):

- Yes No

This student may carry this medication (applicable to high school students, except for inhalers and EpiPens):

- Yes No

This student is both capable and responsible for self-administering this medication (applicable to high school students, except for inhalers and EpiPens):

- No Yes – Supervised Yes – Unsupervised

Signature: (**Stamp NOT ACCEPTED**):

Date:

Phone:

Physician's Name:

Address:

TO BE COMPLETED BY PARENT / GUARDIAN

I request that (check appropriate direction below):

- School personnel store and administer the medication to the above-named student as prescribed, which shall be done in the presence of another adult, except in emergencies.
- School personnel and/or clinic volunteer store the medication ONLY. The above-named student shall be responsible for self-administering the medication without supervision or monitoring by school personnel (applicable to high school students only, except for inhalers and EpiPens).
- The above-named student is allowed to carry and self-administer nonprescription medication without the supervision or monitoring by school personnel (only applicable to high school students ONLY).

I understand and agree that all medication MUST BE in the ORIGINAL CONTAINER, clearly marked with the student's name, name of medication, and prescribed dosage.

Parent / Guardian Name:

Relationship:

Signature:

Date:

WRITE PROCEDURES ON BACK

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