Northville Public Schools

Early Childhood Education and Extended Day Programs
Medication Prescription/Parent Authorization Form

Student Name:_____ Birthdate: _____ Teacher: _____ Grade: _____ School Year: _____

To be completed by physician/licensed prescriber for any prescription or over-the-counter medication:

	Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions
1						
2						
3						

*Routes ~ oral (pill/capsule/chewable, liquid) ~ inhaled (inhaler, nebulizer) ~ topical skin application ~ topical (eye drop, ointment) ~ topical ear drop ~ injection ~ other (list)

List minimal frequency between doses (especially if dispensed as needed "PRN"): _____

If dispensed as needed (PRN), list symptoms/conditions under which medication is to be given: _____

Reason for medication (optional): Medication #1_____Medication #2_____Medication #3_____

Special Instructions: _____

It is medically necessary for the student to carry or self-administer this medication yes no For self-administration, see back.

Start date if not beginning of the school year: _____ Stop date if not the end of the school year: _____

_____ _____ _____
Physician's signature Date Physician's Printed name

Physician's Phone #: _____FAX #: _____ Address: _____

To be completed by parent/guardian:

I request and give permission for (name of child) _____ to receive the above medication(s)/treatment at school according to standard school district policy and for the physician or physician's staff and school district staff to share information needed to assist my child with medication needs. Schools require parent/guardian to bring medication in its original container. All medication must be labeled with the student's name.

_____ _____
Parent/Guardian signature Date