



Northview Public Schools

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) **2026-2027**

School: _____

Note: This form must be **complete** to allow the school to administer medication to your student. **All Michigan requirements in bold.**

Please complete the following checklist, created in alliance with state law, prior to returning this form to the school:

- ☐ An updated copy of this form must be completed at the start of each school year and with any medication changes (including dose/time)
- ☐ Only **one medication per form**, please. Forms listing more than one medication will not be accepted.
- ☐ Prescription medication must be provided to the school in the **original container, with the original pharmacy/prescriber label intact.**
- ☐ Each **prescription medication requires a provider signature** to be accepted **see last section of form for self-carry emergency medication*
- ☐ Non-prescription medication must be in the **original container**, and any dosage outside of label instruction requires provider signature.
- ☐ The school may not accept medication unless it is **provided to the school office by a parent/responsible adult** with this form in hand/on file.
- ☐ The quantity of each medication provided to the school **must be verified** with district staff and child's parent/responsible adult prior to accepting.
- ☐ The school nurse (RN) will contact the prescriber, as allowed by HIPAA, if a question arises regarding the child and/or the child's medication.
- ☐ If a student is Medicaid eligible, school health services may be billed on behalf of the school (this will not impact future Medicaid Plan benefits)

Student Name: _____ Date of Birth: _____ Grade: _____

Allergies: _____ ☐ NONE KNOWN Diagnosis: _____ Symptoms: _____

Medication Name: _____ Dose: _____ ☐ DOSE PER BOTTLE INSTRUCTIONS (non-prescription medication only)

Route: _____ Time: _____ ☐ AS NEEDED Specific Instruction/Known Side Effects: _____ ☐ NONE EXPECTED

PRESCRIBER'S AUTHORIZATION (REQUIRED for prescription medication)

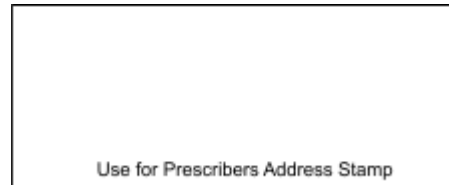
Prescriber's Name/Title: _____

Telephone: _____ Fax: _____

Address: _____

Prescriber's Signature: _____ Date: _____

(Original signature or signature stamp ONLY)



PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home/Cell Phone #: _____ Work Phone #: _____

*SELF-CARRY/SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of medication (only emergency medication) may be authorized by the prescriber and must be approved by the school nurse according to the School Nurse Program medication policy.

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

Signature

Date

School RN approval for self-carry/self-administration of medication: _____

Signature

Date

Order reviewed by the school RN : _____

Signature

Date