West Bloomfield PRESCHOOL ACADEMY

West Bloomfield SCHOOL DISTRICT

WBSD KIDS CONNECT

West Bloomfield School District
5810 Commerce Rd.
West Bloomfield, MI 48324

General Medication Administration Form

To ensure the safety and well-being of all children, families must provide clear and accurate medical information for their child. A separate form must be completed for each medical condition. Please list only the medications and care needs required for that specific condition on each form.

For example:
Diabetes → Insulin, glucose tabs (1 form)
Seizures → Rescue medication (1 form)
Asthma → Inhaler (1 form)

If multiple medications or supports are required for a single condition (e.g., insulin and glucagon for diabetes), please list them together under that specific condition.

Both prescription and nonprescription medications require a completed emergency care plan form signed by a physician and parent/guardian.

TO BE COMPLETED BY PARENT/GUARDIAN:

STUDENT'S NAME:	**DATE OF BIRTH :**	**TODAY'S DATE:**
SCHOOL:	**TEACHER:**	**GRADE:**
PARENT/GUARDIAN CONTACT INFORMATION		
NAME:	**RELATIONSHIP:**	**PRIMARY PHONE:**
NAME:	**RELATIONSHIP:**	**PRIMARY PHONE:**

TO BE COMPLETED BY THE PHYSICIAN:

REASON FOR MEDICATION (DIAGNOSIS):
IF CHILD IS EXPERIENCING THE FOLLOW SIGNS OR SYMPTOMS, FOLLOW ACTION PLAN:
STEP BY STEP ACTION PLAN: **1.** **2.** **3.**

Medications Listed on Action Plan
NAME OF MEDICTION #1 _____DOSAGE:_____ **Expiration Date:_____** ☐ **Prescription** **(must be in the original pharmacy container with the original prescription label)** ☐ **Non-Prescription** **(must be in the original store box and labeled clearly with the child's first and last name)** **STORAGE: ___Room Temperature ___Refridgerated**
NAME OF MEDICTION #2 _____DOSAGE:_____ **Expiration Date:_____** ☐ **Prescription** **(must be in the original pharmacy container with the original prescription label)** ☐ **Non-Prescription** **(must be in the original store box and labeled clearly with the child's first and last name)** **STORAGE: ___Room Temperature ___Refridgerated**
NAME OF MEDICTION #3 _____DOSAGE:_____ **Expiration Date:_____** ☐ **Prescription** **(must be in the original pharmacy container with the original prescription label)** ☐ **Non-Prescription** **(must be in the original store box and labeled clearly with the child's first and last name)** **STORAGE: ___Room Temperature ___Refridgerated**

I certify that I am a licensed healthcare provider and have reviewed and completed this form to the best of my knowledge. The information provided is accurate and reflects the current health status of the child. Any medical conditions, restrictions, and/or recommendations have been noted, and the child is able to participate in program activities as indicated above.

PHYSICIAN'S NAME:	PHYSICIAN'S PHONE:	PHYSICIANS ADDRESS:
PHYSICIANS' SIGNATURE:		**DATE:**
X		X

TO BE COMPLETED BY CHILDS LEGAL PARENT/GUARDIAN:

I agree with this medical plan as written and for the school staff to share this information with those that need to know and for staff to contact the treating healthcare professional for clarification of this plan, if needed. I authorize school personnel to contact the above physician with questions or concerns relative to this authorization and medication.

PARENT/GUARDIAN NAME:	PARENT/GUARDIAN PHONE:	PARENT/GUARDIAN ADDRESS:
PARENT/GUARDIAN SIGNATURE:		**DATE:**
X		X