



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

All medications must be delivered by a parent/guardian in original, labeled pharmacy packaging (unexpired). Medications will not be accepted without a completed authorization signed by both the parent/guardian and healthcare provider.

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 request and authorize that my child (named above) receive the medication listed on this form during school hours according to the prescribing healthcare provider's instructions.

I understand that authorized school personnel will administer this medication in accordance with school district policy.

I agree to hold the Haslett Public Schools Board of Education and its employees harmless from complications related to this medication when it is administered as prescribed.

Parent/Guardian Signature: _____ Date: _____

Section 4: Authorization of Release of Medical Information

I authorize school personnel to communicate with the prescribing healthcare provider regarding my child's health condition and the medication listed on this form. Relevant information may be exchanged by telephone, fax, or written communication as needed for safe medication administration at school. This authorization is valid for the current school year unless revoked in writing.

Parent/Guardian Signature: _____ Date: _____



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Section 5: Emergency Medication and Emergency Action Plan Acknowledgment

For students with emergency medications (such as epinephrine, seizure rescue medications, inhalers, or other emergency treatments), an Emergency Action Plan (EAP) may be developed based on the prescribing provider's instructions.

I understand and acknowledge that:

- The Emergency Action Plan and medication administration instructions will be used by school personnel to respond appropriately to my child's medical condition.
- Designated school staff who are responsible for the student during the school day or school-sponsored activities may have access to the Emergency Action Plan and medication instructions as needed to ensure the student's safety.
- Information will only be shared with staff who have a legitimate educational or safety responsibility for my child.

Parent/Guardian Signature: _____ Date: _____

Section 6: Self-Carry Authorization (Emergency Medications)

If approved by the healthcare provider and parent/guardian, students may carry and self-administer the medication listed on this form during school hours and school related activities.

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

Healthcare Provider: 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.

Provider Signature: _____ Date: _____

Parent/Guardian: I give permission for my child to carry and self-administer this medication. I understand the school is not responsible for ensuring medication is taken as prescribed, as the student has been instructed in the proper use of this medication by their healthcare provider.

Parent/Guardian Signature: _____ Date: _____

Student Agreement for Carrying and Administering Medication at School:

I agree and understand to:

- Always carry medication in its original and properly labeled container
- Never Share my medication with another person
- Take medications only at prescribed time, frequency, and dose
- Medication Administration Authorization must be completed and kept in the school office.

Student Signature: _____ Date: _____