ADMINISTRATION OF MEDICATION CONSENT FORM

Medications (both prescription and over the counter) may be administered at school by school personnel **when necessary** for school attendance. This **completed** form along with the medication and/or special equipment items are to be brought to the school by the parent/guardian. **Medication will not be administered at school until these criteria are met**.

As a parent, I understand my responsibilities are:

1. ***To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy. (Parents may request that the pharmacist dispense <u>two</u> bottles of medication, one for home and one for school.)***
2. ***To provide the school with the written doctor's instructions for medication administration during school hours.***
3. ***To inform the school of any medication and/or medical changes.***

Medication means: "*Medication" shall include all medicines including those prescribed by a physician and any non-prescribed (over-the-counter) drugs, preparations, and/or remedies*.

Student: _____ Birthdate: _____ School Year: _____

Parent/Guardian Name: _____ Phone Number: _____

Doctor's Name: _____ Dr. Phone Number: _____

Doctor's Address: _____

I, _____ , _____ of
Name *Relationship*

_____ , do hereby request that the building administrator or his/her designee, administer the (prescribed) medication listed below or procedure (listed below) as directed.

Reason / Condition for medication: _____

Name of Medication: _____

Form of Medication: ☐ tablet/capsule ☐ liquid ☐ inhaler ☐ injection ☐ nebulizer ☐ Other

Dosage: _____ Time ***during*** school _____

Restrictions / and or side effects: ☐ none anticipated ☐ yes

Please describe _____

_____

Storage requirements: ☐ none ☐ refrigerate ☐ other

This student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes

**Additional information: ☐ attached ☐ on back of form

1. ***This also authorizes an exchange of information, as necessary, between the school and my child's health care provider***.
2. *If your child is Medicaid eligible, school health services may bill on behalf of the school. School district billing will not impact future benefits of your family's Medicaid plan. This would include releasing Personally Identifiable Information (PII) about my child (including date of birth, disability, gender, school, date of services, type of services) to Michigan Medicaid and its billing agencies for Medicaid reimbursement of School-Based Services.*

Signature of Parent/Guardian: _____ Date: _____

Signature of Student if Adult: _____

_____ _____
Physician's name printed and NPI# Physician's signature

Physicians's address: _____

Phone: _____ Fax: _____ Date: _____

A copy of this form will be kept in the student's CA-60 and nurse's office and will be renewed annually or whenever the prescription changes within the current school year.