OKEMOS PUBLIC SCHOOLS

Authorization for Administration of **Prescription Medication**

Name of Student: ______________________________ Birthdate: __________________________ Grade: ___	Teacher: ____________________ School: ____________________	Date form received
Is this student enrolled in childcare? (Please circle) Yes No		

To be completed by a Physician

Diagnosis/Purpose of Medication: ____

Name of Medication: ____

Dosage:__________________________ Frequency: __________________ Time: ____________

Anticipated Duration: ____ (if indefinite, so state)

Form of Medication/Treatment: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer

How is medication to be given (schedule and dose to be given at school)? __________________________

____

Should the school be aware of any adverse reactions or precautions? _______________________________

____

The student is both capable and responsible for self-administering this medication:
☐ No ☐ Yes, supervised ☐ Yes, unsupervised

The student may carry this medication: ☐ Yes ☐ No

Date: __________________ Physician: ____

Address: ____ Phone: __________________________

The undersigned parent/guardian authorizes the Okemos Public Schools through its administrators and/or staff to administer medication or to supervise the taking of medication by my child.

It is understood that the undersigned parent/guardian shall immediately notify the school personnel in writing in the event the prescription shall be discontinued or modified.

The medication must be brought to school in a container appropriately labeled by a physician or pharmacy. Refills of the prescription shall be the responsibility of the parent/guardian.

Further the undersigned shall release and indemnify the school district and its employees from any liability or damage which may result to the student from the administration of said medication as prescribed by the physician.

Signature of Parent/Guardian: ____ Date: _____________

Home Phone: ___________________________________ Cell Phone: ___________________________________

Emergency Phone: ________________________________

Name of Doctor: ________________________________ Doctor's Phone: ________________________________

Bennett Woods Fax #: 517-351-1912