ST. JOHNS PUBLIC SCHOOLS
HEALTH SERVICES FORM

PERMISSION FORM FOR PRESCRIBED MEDICATION

Michigan law requires schools to have a written physician's order and parent/guardian authorization for administration of medication.

Date form received by the school: _____

Student_____ Date of birth, or age:_____

School: _____ Grade: _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Reason for medication: _____

Name of medication: _____

Form of medication/treatment

☐ Tablet/capsule ☐ Liquid ☐Inhaler ☐Injection ☐Nebulizer ☐Other _____

Instructions (Schedule and dose to be given): _____

_____

Start: ☐ date form received Other date: _____

Stop: ☐end of school year Other date/duration: _____

Restrictions and/or important side effects:

☐ None anticipated

☐Yes. Please describe._____

_____

SPECIAL AUTHORIZATION: FOR INHALERS, DIABETICS, AND EPI-PENS

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

☐No ☐Yes – Supervised ☐Yes – Unsupervised

This student may carry this medication: ☐No ☐Yes

Please indicate if you have provided additional information:

☐On the back side of this form ☐ As an attachment

Date: _____ Physician's Signature: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for (name of child) _____ to receive the above medication at school and school sponsored functions and will not hold the Board of Education or its personnel responsible for complications related to the medication or administration of the medication. I understand this health information can be shared when it is educationally relevant for academic progress, necessary for providing health services including emergency care, or essential to ensure the protection of other students and school personnel.

Date: _____ Signature._____ Relationship:_____