CALHOUN CHRISTIAN SCHOOL

Academic Excellence | Upholding God's Truth | Teaching Children to Serve

Medication Administration Authorization

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

The State of Michigan Public Act 157 requires that we have written permission from the parent/guardian before administering medication at school. Both the parent/guardian and the prescriber must sign this form and provide written instructions which are consistent with prescription directions.

- Medication must be hand-delivered to school by a parent/guardian (students are not allowed to bring in medication – any medication brought in by a student will not be administered)
- All medication must be in a properly labeled container bearing the pharmacist's label of contents for prescription medications, or the original over-the-counter (OTC) medication container. No expired medication will be administered.
- A separate authorization form must be completed for each medication and each student in the same family
- The parent/guardian assumes responsibility to inform the office of any change in medication

STUDENT INFORMATION

STUDENT'S NAME: _____ **DATE OF BIRTH:** _____ **GRADE:** _____

NAME OF MEDICATION: _____

Condition for which drug is being administered: _____

Dosage: _____ **Route:** ☐ oral ☐ eye ☐ ear ☐ other: _____

Time of Administration: ☐ Lunchtime ☐ Other (specify): _____

Side Effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____
(month / day / year) (month / day / year)

I request and give permission for _____ (student) to receive the above medication/treatment at school according to standard school policy and for the prescriber and school staff to share information needed to assist my student with medication needs.

Parent/Guardian Signature _____ **Date** _____

PRESCRIBER

PRESCRIBER'S NAME: _____

Telephone: _____ Fax: _____

Prescriber's Signature: _____

IF APPLICABLE: Prescriber's Authorization for Self-Administration: ☐ YES ☐ NO

SELF-ADMINISTRATION

By signing below, the student who is authorized by their physician to self-administer medication agrees to comply with CCS guidelines regarding the use and care of medication for the protection of themselves and other students. If the student is found to be non-compliant, they will lose the ability to self-administer.

Parent/Guardian Signature Authorizing Self-Administration: _____

Student Signature for Self-Administration: _____

SCHOOL OFFICE/ADMINISTRATION AUTHORIZATION

School Office/Administration's Approval for Self-Administration: ☐ YES ☐ NO

School Office/Administration Signature _____ **Date** _____