Permission Form for Medication Grosse Pointe Public School System

Pursuant to the MDE Model Policy for Administering Medication to Pupils at School as adopted in the Grosse Pointe Public School System,"medication" includes prescription, non-prescription and herbal medications, and includes those taken by mouth, by inhaler, those that are injectable, and those applied as drops to eyes, nose, or medications applied to the skin. For the purposes of this policy the term "physician" means any health care provider licensed by the State of Michigan to prescribe medication.

Student Name: School:

Date of Birth: Grade:

I. Physician Permission to Administer Prescribed Medication

To be completed by the physician or authorized prescriber:

General Permission to Administer Prescription Medication:

I give permission to the school district to administer prescription medications prescribed by me or other members of my practice to the student above per the instructions listed on the original packaging for the prescription medication (this permission is in effect for the entire 2017 18 school year).

Date: _____ Signature: _____

Physician or Other Authorized Prescriber

Specific Prescription Medication Authorization:

Name of medication: _____

Form of medication/treatment: Tablet ☐ Liquid ☐ Injection ☐ Nebulizer ☐ Other ☐

Reason for medication: _____

Instructions (schedule and dose to be given at school): _____

Start: ☐ Date form received Other dates: _____

Stop: ☐ End of school year Other dates/duration: _____

☐ For episodic/emergency events only

Restrictions and/or important side effects: __ None anticipated

☐ Yes, Please describe: _____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other: _____

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

Date: _____ Signature: _____

Physician or Other Authorized Prescriber

II. Physician Permission to Administer Over the Counter Medications

The student has permission to receive the following over the counter medications as requested by the parent dosed per the label on the package:

Medication Name:	School has Permission to Administer (Y or N)	Self Administer (Yes or No):	Student May Carry On Person (Yes or No):
Pain Relief Aspirin	NA		
Pain Relief Ibuprofen			
Pain Relief Acetaminophen			
Cold Symptom Relief			
Cough Drops			
Other:			

Date: _____ Signature: _____

Physician or Other Authorized Prescriber

Please attach a separate sheet indicating any known restrictions or allergies for OTC medication.

Physician's Name: _____
Address: _____
Phone Number: _____

To be completed by parent/guardian:

I request that (name of child) _____ receive the above medication(s) at school

I request that (name of child) _____ be allowed to self administer and/or self possess the above

Date: _____ Signature: _____

Relationship: _____

This form expires at the end of each school year.