Davison Community Schools
1490 N. Oak Rd. Davison, MI 48423
Phone (810) 591-0913 Fax (810) 591-2674

Authorization to Administer Medication

Student Name _____ **School** _____

Teacher _____ **Room Number** _____ **Grade** _____

Physician's Order **(Must be completed by physician or designee)**

Name of medication _____ Reason for medication _____

Dose _____ Time to be Given _____

For episodic/emergency use only ___ yes ___ no

Route to be given (please check)
___ by mouth (___ capsule ___ tablet ___ liquid)
___ injection
___ inhaler/nebulizer
___ drops
___ other _____

Side effects to observe: ___ none anticipated ___ yes, describe _____

Special storage considerations: ___ none ___ refrigerate

Start date _____ Stop date _____ End of school year _____

Self-Administration

This student is both capable and responsible for carrying and self-administering this medication. ___ Yes ___ No

Physician Name _____ Phone Number _____

Address _____

Physician Signature _____ Date _____

Parent/Guardian Authorization to Administer Medication **(Must be completed by parent or guardian)**

I have read the school's policy and procedures pertaining to administration of medication. I agree to follow the procedures and request that (student's name) _____

_____ Receive the medication specified above at school according to school policy and procedure.

_____ Request that my child be allowed to self-administer the medication specified above according to school policy and procedure. (***Can only be requested with physician's written approval above.)***
(Note: School policy does not allow students to self administer controlled substances.)

Parent/Guardian Signature _____ Date _____

Home phone _____ Cell phone _____ Work phone _____

Office Use Only

Date received _____ *Number of pills received* _____ *Date medication returned to parent* _____

Please Fill Out Both Sides!

DAVISON COMMUNITY SCHOOLS

ALLERGY HEALTH CARE PLAN

Student's Name _____ Date of Birth _____

Teacher _____ Grade _____

Parent/Guardian _____ Phone Number _____

Work Number _____ Cell Number _____

Emergency Contact _____
(Name) (Relationship) (Phone Number)

Doctor's Name _____ Phone Number _____

ALLERGY TO: _____

Asthmatic? Yes* _____ No _____ (*High risk for severe reaction)

SIGNS OF AN ALLERGIC REACTION INCLUDE:

	Systems	Symptoms
	*Mouth	Itching, swelling of the lips and/or tongue; drooling
	*Throat	Itching and/or a sense of tightness in the throat; hoarseness and hacking cough
Q	*Skin	Hives; itchy rash and/or swelling about the face or extremities
	*Stomach	Nausea, abdominal cramps, vomiting and/or diarrhea
	Lung	Shortness of breath; repetitive coughing and/or wheezing
	Heart	"Passing out"; weak, rapid pulse

The severity of symptoms can quickly change.

*All above symptoms can potentially become life-threatening.

ACTION

If he/she should accidentally be exposed, the following procedure should be followed:
(Please check all that apply)

_____ Call 911
_____ Give medication: _____
_____ No medication is necessary. Please observe only.
_____ No action is necessary. It is not a life-threatening allergy.
_____ Other _____

Comments: _____
_____

I understand that this information will be shared with school staff responsible for the care and management of the above health concern for my child.
Reviewed by:

Parent/Guardian _____Date _____
School Representative _____Date _____
Physician _____ Date _____

Please Fill Out Both Sides!