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* _____