New Lothrop Area Public Schools

Medication Administration Authorization

"Medication" refers to any prescription, over-the-counter (OTC), homeopathic, herbal, vitamin, or mineral preparation. **If it is necessary for medication be provided during school hours, these regulations must be followed in order for a student to be able to receive their medication during school hours:**

➢ Prescription medications must be prescribed in writing on a school medication administration authorization form and **signed by the treating physician/licensed prescriber and parent,** and must be renewed at least annually, generally at the start of each school year and any time medication needs change.

➢ Any over the counter (OTC) medication must be provided with a school medication administration authorization form with a **parent signature** (no physician signature required for OTC medications)

➢ Medication must be brought to school **in the original pharmacy** or **OTC container** labeled with the student's name and medication name, strength, dosage, route of administration, and time(s) to be given.

➢The parent/guardian is expected to deliver medication and related equipment/supplies, as ordered, to the school as needed. **Students are not permitted to deliver medication to school with the exception of inhalers.** Certain medications will also need to be counted out with a staff member if not in a sealed original container. School staff will notify parents/guardians when there is approximately a 7-10 day supply of medication left in order to give families ample time to refill the medication.

➢Additional forms are also required for students with the following health conditions where a safety plan needs to be in place:

- ➢Allergy/Anaphylaxis (Food or Environmental)
- ➢Asthma
- ➢Diabetes
- ➢Seizures

If you would like more information regarding Administration of Medication in Schools you can visit: www.michigan.gov/schoolhealthservices

Forms can be brought in with the medication or faxed back to the corresponding office at:

- ➢High School- 810-638-5057
- ➢Elementary School-810-638-7289

*Please note, medication can not be administered to a student without the proper paperwork completed.

New Lothrop Area Public Schools

Authorization to Administer Medication at School

Required for all Prescription and Non-Prescription Medications

School: ○**Elementary School** ○**High School**

Student Name:_____ Date of Birth:_____ Grade: _____

Teacher (Elementary only):_____

Completed by the physician (if prescription medication) or parent (if over the counter)

***One Authorization to Administer Medication form must be filled out for EACH medication the student may take at school**

Name and dose of medication_____

Reason for Medication (optional)_____

Form of Medication/Treatment ○Tablet/Capsule ○Liquid ○Inhaler ○Injection ○Other

Instructions (**frequency/time** and **dose** to be given at school, please be specific)

_____

_____

Start: ○ Date form received ○ **Other dates**:_____

End: ○ End of school year ○ **Other dates/Duration:**_____

○ For episodic/emergency events only

With principal, physician and parent approval and per school policy, select cases may be reviewed and permission granted to self administer certain medications **(inhalers/epi-pens only)**

➢This student may carry and is responsible for self administering an inhaler: ○**YES** ○**NO**

➢This student may carry and has been instructed on how to self administer an epi-pen/epinephrine auto-injector per school policy: ○ **YES** ○ **NO**

➢**Restrictions and/or important side effects:** ○ None anticipated ○ Yes (If "Yes", please explain)

_____

_____

➢**Special storage requirements:** ○ None○ Refrigerate ○ Other

Physician Signature if prescription medication: _____

Physician Name: _____ Date:_____

Address:_____

Phone Number: _____ Fax: _____

To be completed by Parent/Guardian

I request that _____ **(Name of Child)** receive the above medication at school according to standard school policy. I give permission for exchange of verbal and written communication between the physician and school nurse and/or designated school staff regarding my child's medication regimen. I request that my child be assisted in taking the medication described above at school by authorized personnel or permitted to medicate themselves as also authorized by myself and my physician.

Signature:_____ Date: _____

Home Phone: _____ Emergency phone: _____

For staff use only

○Parent signed ○Dr. Signed ○Med received and/or ○Student carries(labeled) ○Profile updated

○Additional Staff notified: _____ Initials/Date _____

Revised February 2023