Active for School Year: ________________

STUDENT MEDICATION REQUEST FORM

This form must be *completed in full and returned with a physician's signature* to current school office before administration of medication can take place within the school. *OTC medications also require a physician's signature.*

Student Name & DOB:	**School & Grade:**
Parent/Guardian:	**Phone:**
Parent/Guardian:	**Phone:**
Name of Prescription or OTC Medication:	
Form of Medication (circle one): Tablet/Capsule Liquid Inhaler Medi-pen Other: __________	
Time to be administered:	
Is this medication for episodic or emergency events only? (circle one): Yes No	
Is the student able to self-carry this medication? (circle one): Yes No	
Possible side effects from medication:	
Health Care Provider Signature: **Printed Name:**	**Phone:**
Preferred Hospital:	**Fax:**
Emergency Contact:	**Phone:**

I give permission for school personnel to share this information, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and equipment devices. I understand and agree that when school personnel administer medication to my child as indicated above, I will not hold the personnel and school district liable in any criminal action or for civil damages. Reference: Act #157, Public Acts of 1971, effective 11/24/1971, Section 378.

All medications must be collected by a parent or guardian within one week of the last day of classes for students. Any medications left after that time will be properly disposed of.

____

Parent Signature **Date**

School Office Use Only	Administration Office Use Only
Date Received: **Location of Medication:**	**Date Received from Building:** **Date Recorded:**
Reminder: **Scan/Email to School Nurse & Administration Office**	**Reminder:** **Set Alert in PowerSchool, Upload to CEO**

Updated on 4/9/2018