Ypsilanti Community Schools
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS
School Year 2019-20

Student Information

Student Name _____ Birth Date_____

School Building_____ Teacher_____ Grade_____

Medication Information

Diagnosis or Reason for Medication_____

Medication and Dosage_____

Form: ☐ Tablet ☐ Capsule ☐ Liquid ☐ MD Inhaler ☐ Nebulizer ☐ Ointment ☐ Other_____

Amount to be Given_____ Route: ☐ Oral ☐ Injection ☐ Rectal ☐ Inhaled ☐Other_____

Time of Administration_____

Important Side Effects: ☐ None anticipated ☐ Yes (describe) _____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other_____

Start: ☐ Date form received_____ ☐ Other date_____

Stop: ☐ End of school year ☐ Other date_____ (Note: permission must be renewed each school year)

Important Notice to Parent and Physician:

1. Self-carried means the student will possess and self-administer the medication without supervision. Controlled substances are not allowed to be self-carried. Physician and parent authorization is required and no records are kept by the school.
2. Medication stored by the school for the student, even if self-administered, must have both physician and parent authorization. Records will be kept by the school of each dose taken.

Physician Authorization

☐ School personnel will administer this medication

--------- OR ---------

☐ This student is capable of and may self-administer this medication under the supervision of school personnel.

--------- OR ---------

☐ This student is capable of and may carry and self administer this medication (No controlled substances).

Physician's Name_____
(please print)

Physician's Signature_____

Date_____

Phone #_____ FAX#_____

Parent/Guardian Authorization

☐ School personnel will administer this medication.

---------- OR ---------

☐ This student is capable of and may self-administer this medication under the supervision of school personnel.

---------- OR ---------

☐ This student is capable of and may carry and self-administer this medication (No controlled substances).

Therefore, I understand and agree to accept:

*any risk that the medication may be lost or stolen,

*that the student may misuse the medication,

*that the school will not keep any record of the dates or times of medication administration,

*that this privilege will be revoked if problems arise from inappropriate use.

Parent/Guardian's Signature_____

Date_____

Home Phone #_____Work #_____

School Acceptance (needed only for self-administered/self carried medication)

Student has demonstrated safe self-administration of medication. ☐ Yes ☐ No

School Nurse's Signature_____ Date_____ Building Principal's Initials_____

Revised 2019 Original > Building Main Office Copy > School Nurse