MPPS Permission for School Medication
Effective Date: _____School Year: _____

Student:_____Date of Birth: _____

PRESCRIPTION AND OVER THE COUNTER MEDICATION

TO BE GIVEN BY SCHOOL PERSONNEL DURING SCHOOL DAY ONLY WHEN UNABLE TO GIVE AT HOME.

1. Medication: _____Dosage: _____
Route: _____Time: _____Reason: _____
Form of Med: Tablet ____ Liquid ____ Inhaler _____ Nebulizer _____ IM _____ SQ _____ Suppository _____
Student Allowed to Self-Administer: Yes: _____ No: _____ Staff to Administer: Yes: _____ No: _____
Side Effects to Watch for _____
Staff Actions if Side Effects Observed _____
Special Instructions _____
_____Shake: _____ Refrigerate: _____

2. Medication: _____Dosage: _____
Route: _____Time: _____Reason: _____
Form of Med: Tablet ____ Liquid ____ Inhaler _____ Nebulizer _____ IM _____ SQ _____ Suppository _____
Student Allowed to Self-Administer: Yes: _____ No: _____ Staff to Administer: Yes: _____ No: _____
Side Effects to Watch for _____
Staff Actions if Side Effects Observed _____
Special Instructions _____
_____Shake: _____ Refrigerate: _____

Physician Signature: _____Date: _____
Physician Printed Name: _____ FAX: _____
Address: _____Phone:_____

- **We, the parents or legal guardians, request that the above ordered medication be administered to our child by a member of the school staff in accordance with our physician's instructions.**
- **We will notify the school immediately if we change physicians or if the medication is changed in any way.**
- **We agree to bring the medication to school in the original container from the pharmacist, properly labeled, including name of the student, doctor, date, dosage, time of administration, name of medication, and method of administration.**
- **We understand that any and all new medication must be started by the parent/guardian at home 24 hours prior to next school day as indicated by the Michigan Department of Education.**
- **"Over the Counter" medication will be in the manufacturer's original container with the child's name written on the label, and given in accordance with our physician's written instructions.**
- **Medication improperly labeled or contained, will not be administered at the school.**
- **I also authorize the Designated Trained School staff to talk with the Prescriber or Pharmacist should a question arise concerning the medication. I have been given a copy of the School Medication Guidelines and I understand them.**

Parent/Guardian Signature_____Date_____

Designated Staff Signature_____Date_____