OKEMOS PUBLIC SCHOOLS

Authorization for Administration of Prescription Medication

Name of Student_____ **Birth Date** _____ **Grade** _____	**Teacher** _____ **School** _____	**Date form Received**
Is this student enrolled in child care? (Please circle) Yes No If Yes, in KEEP____ or Before/After ____?		

To be completed by a Physician

Diagnosis/Purpose of Medication_____

Name of Medication_____

Dosage_____ **Frequency**_____ **Time**_____

Anticipated Duration_____ **(if indefinite, so state)**

Form of Medication/Treatment ❑ **Tablet/Capsule** ❑ **Liquid** ❑ **Inhaler** ❑ **Injection** ❑ **Nebulizer**

How is medication to be given (schedule and dose to be given at school)? _____

_____

Should the school be aware of any adverse reactions or precaution? _____

_____

The student is both capable and responsible for self-administering this medication:
❑ **No** ❑ **Yes, supervised** ❑ **Yes, unsupervised**

The student may carry this medication ❑ **yes** ❑ **no**

Date _____ **Physician** _____

Address _____ **Phone** _____

The undersigned parent/guardian authorizes the Okemos Public Schools through its administrators and/or staff to administer medication or to supervise the taking of medication by my child.

It is understood that the undersigned parent/guardian shall immediately notify the school personnel in writing in the event the prescription shall be discontinued or modified.

The medication must be brought to school in a container appropriately labeled by a physician or pharmacy. Refills of the prescription shall be the responsibility of the parent/guardian.

Further, the undersigned shall release and indemnify the school district and its employees from any liability or damage which may result to the student from the administration of said medication as prescribed by the physician.

Signature of Parent/Guardian_____ **Date**_____

Home Phone: _____ **Cell Phone:** _____

Emergency Phone:_____

Name of Doctor: _____ **Doctor's Phone:** _____