



Haslett Public Schools
Authorization for Administration of Prescription Medication
Murphy Elementary School Phone: 339-8253
Fax # 339-4830

Date form was received at school _____

Name of Student: _____

Birth Date: _____ Grade: _____ Teacher: _____

To be completed by the physician:

Name of medication: _____

Instructions (Schedule and dosage to be given at school): _____

Reason for medication: (Optional) _____

Form of medicine/treatment:

- Tablets/capsules
 Liquid
 Inhaler
 Other
 Additional dosage permitted in emergencies only by telephone call with parent.

Restrictions and/or pertinent effects: None anticipated.
 Yes, please describe: _____

Special storage requirements: None Refrigeration Other

Start Date if not the beginning of school: _____

Stop date if not end of the school year: _____

Physicians Signature _____ Date _____

Physicians Name: _____ Phone #: _____

Address: _____

This student is both capable and responsible for self-administrating this medication. This is for certain medications only (i.e. Inhalers)

- No Yes/Supervised

If yes, complete below.

Date: _____ Signature: _____

To be completed by parent/guardian

I request that _____ receive the above medication at school according to standard school policy. (Name of student.)

Date: _____ Signature: _____ Relationship: _____