Haslett Public Schools

Authorization for Administration of Prescription Medication

Wilkshire - Murphy - Ralya - Elementary School (please circle school)

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: ________________________________

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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:_______________