Haslett Public Schools
Authorization for Administration of
Over The Counter Medication
Haslett Middle School

Date form was received at school _____

Name of Student:_____ Birth Date: _____

School:_____ Grade:_____

To be completed by the parent/guardian.

Name of medication: _____

Reason for medication: (Optional) _____

Amount to be taken: _____

Form of medicine/treatment:

· Tablets/capsules · Liquid · Inhaler · Other

Instructions (Schedule and dose to be given at school)

· 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 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:_____