



**Haslett Public Schools
Authorization for Administration
of Prescription Medication
Haslett Middle School**

Date form was received at school _____

Name of Student: _____ Birth Date: _____

School: _____ Grade: _____

To be completed by the physician and 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 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: _____