MEDICATION RELEASE FORM

NEW LOTHROP ELEMENTARY SCHOOL
9387 Genesee Street – P.O. Box 279 – New Lothrop, MI 48460
PH: (810) 638-5026 ★ Fax: (810) 638-7289

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RETURN ONLY TO GIVE
Authorization to Administer Prescription Medication During School Hours

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Michigan law requires a physician's written order as well as parent/guardian authorization for school personnel to administer prescription medication to a child during school hours.

Date Form Received By School: _____ Student: _____

Teacher: _____ Date of Birth: _____ Age: _____ Grade: _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of Medication: _____

Reason for Medication: (Optional) _____

Form of Medication/Treatment:

❍ Tablet/Capsule ❍ Liquid ❍ Inhaler ❍ Injection ❍ Nebulizer ❍ Other:

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

Start date for medication: / / End date: / / ❍ Give only for episodic/emergencies only

Restrictions and/or important side effects: ❍ None anticipated

Possible side effects to look for: _____

Special storage requirements: ❍ None ❍ Refrigerate ❍ Other: _____

This student is both capable and responsible for self-administering this medication:

❍ No ❍ Yes, with supervision ❍ Yes, no supervision necessary

This student may carry this medication: ❍ No ❍ Yes

Additional Information: _____

Physician's Name: _____ Physician's Signature: _____

Address: _____ City/State & Zip: _____

Phone #: _____ Today's Date: _____

TO BE COMPLETED BY THE PARENT OR GUARDIAN

I give my consent for school personnel to administer the medication as described above by my child's doctor.

Today's Date: / / Signature of Parent/Guardian