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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Authorization to Administer Prescription Medication During School Hours * * * * * * * *

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: ____

Name of Medication: Reason for Medication: (Optional) Form of Medication/Treatment: O Tablet/Capsule O Liquid O Inhaler O Injection Nebulizer O Other: Instructions (Schedule and dose to be given at school): Start date for medication: /	TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER
Form of Medication/Treatment: O Tablet/Capsule O Liquid O Inhaler O Injection O Nebulizer O Other: Instructions (Schedule and dose to be given at school): Start date for medication: / End date: / O Give only for episodic/emergencies only Restrictions and/or important side effects: None anticipated Possible side effects to look for: Special storage requirements: O None O Refrigerate O Other: This student is both capable and responsible for self-administering this medication: O No O Yes, with supervision O Yes, no supervision necessary This student may carry this medication: O No O Yes Additional Information: Physician's Name: Physician's Signature:	Name of Medication:
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Address: City/State & Zip:	Adduses:
Phone #: Today's Date:	Phone #: Today's Date:

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: