EAST LANSING PUBLIC SCHOOLS
Authorization for Administration of Medication

Date form received by the school_____

Student Name_____Birth Date_____

Grade_____ Teacher/Classroom_____School_____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER:

Name of Medication_____
Reason for Medication_____
Form of Medication/Treatment:
Dosage_____Time_____a.m./p.m. daily
Or as follows:

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

Start: ❍ Date form received
❍ End of school year
❍ For episodic/emergency events only

Other dates:
Other date/duration:

Restrictions and/or important side effects: ❍ None anticipated
❍ Yes, please describe:_____
_____

Special storage requirements: ❍ None ❍ Refrigerate Other:_____

This student is both capable and responsible for self-administering this medication:
❍ No ❍ Yes-Supervised ❍ Yes-Unsupervised (e.g., inhalers, epipens)

This student may carry this medication: ❍ Yes ❍ No

NOTE: *The final decision for students to take responsibility for medication will be made by the parent, building principal, and teacher. If the student does not use the medication responsibly, the school will take the medication and will contact the parents.*

Please indicate if you have provided additional information:
❍ On the backside of this form ❍ As an attachment

Physician's Name:_____

Address:_____

Phone Number:_____

Physician's Signature:_____ **Date:**_____

TO BE COMPLETED BY PARENT/GUARDIAN:

I request that (name of child)_____receive the above medication at school according to standard school policy.

I request that (name of child)_____be allowed to self-administer the above medication at school according to the school policy.

Date:_____Signature:_____Relationship:_____

THIS FORM IS VALID FOR THIS SCHOOL YEAR ONLY