

Monroe Public Schools Medication Authorization

Student's Name: _____ Grade: _____ Teacher: _____

Parent's Address: _____ Parent's Phone: _____

City/Zip: _____

Attending Physician: _____ Physician's Phone: _____

Physician's Address (include City) _____

To be completed by the physician

Name of Medication _____

Dosage _____ Frequency _____

Time of Administration _____

Anticipated Duration **start date** _____

stop date _____

Purpose of Medication _____

Possible Side Effects _____

Student may carry INHALER:

____ No ____ Yes

Student may carry EPIPEN:

____ No ____ Yes

Students that carry inhalers and EpiPens may not be supervised during administration.

Physician's Signature _____ Date _____

I hereby request that my child be administered his/her prescribed medication at school by the school personnel authorized by the principal. I understand that the medication will be administered exactly as per the instructions of my above named physician. I will notify the school of changes or discontinuation of this medication(s). I further agree that you may contact the physician who prescribed the medication and I hereby authorize him to release to the school nurse any and all information concerning my child's condition and/or treatment.

Unused inhalers may be returned to my child ____ YES ____ NO
ALL other medications must be picked up by parents at years end)

Parent/Guardian Signature _____ Date _____

FOR SCHOOL USE ONLY: This form MUST be kept with medication until discontinued or until the end of the school year and then filed in the cumulative record.

Principal's Signature _____ Date _____

School Nurse's Signature _____ Date _____

Monroe Public Schools

Dear Parent:

Please return the Medication Authorization form **on the back of this letter** to the school with your child's medication.

We also ask that you follow these instructions when sending medication of any kind to the school for administration.

1. Medication must be in the original pharmacy container, properly labeled and include:

Student's Name
Date
Physician's Name
Medication Name
Dosage Amount
Directions of Administration

*Most pharmacies will be glad to provide you with duplicate containers if you request them.

2. Sufficient supply should be sent to the school to insure enough medicine to last for the prescribed length of time. Send at least one week's supply if possible. We discourage the daily carrying of medication for obvious safety reasons.
3. If your child is carrying an inhaler with his/her physician's approval, it is recommended that a second inhaler be kept in the school office.
4. An adult should bring medication to the school office.
5. Unused medication will be discarded unless picked up by parents at the end of the school year.
6. You may come to school to administer medication to your child if you so desire. The school will not be responsible for any medication that has not been prescribed by a physician.

We wish to aid you with any problems your child may have, but also take precautions against possibility of drug misuse and unsafe conditions.

Additional medication forms can be obtained from the Monroe Public Schools website www.monroe.k12.mi.us.

Please contact the school nurse or me immediately if you have any questions concerning the medication policy and procedures.

Thank you,

Principal

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