The GRETA BERMAN ARBETTER

KAZOO SCHOOL

SCHOOL MEDICATION AUTHORIZATION FORM

Name of Child:_____ Date of birth:_____

Kazoo School Phone: (269) 345-3239 FAX # (269) 345-3235

Michigan School Code 49423 allows designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school or maintain or improve the potential for education and learning.

Medication must be in the container in which it was purchased with a pharmacy label attached.

PHYSICIANS ORDER *(to be completed by healthcare provider)* *Only one medication per form*

Name of medication/strength of tablet, capsule or liquid_____

This medication is a controlled substance? Yes No

Dosage: _____ How Often? _____

Time to be given at school: _____ Route to be given:_____

Reason for medication/Diagnosis: _____

Possible Side Effects: _____

☐ Student has been instructed by physician in self-administration and may carry the inhaler with them

☐ Student has been instructed by physician in self-administration and may carry the Epi-Pen with them

Comments: _____

TO BE COMPLETED BY PARENT/GUARDIAN BEFORE GIVING TO PHYSICIAN

I request that my child,_____ , be assisted in taking the above prescribed medication at school by authorized persons. I will comply with the school's policies and procedures. I will notify the school if there are changes in my child's health status, changes in medication or change in health care provider.

I authorize exchange of information between my child's Physician, District Nurse, or site administrator with regard to this medication request

_____ _____ _____

Parent/Guardian Signature Date Emergency Phone

Form must be renewed every 12 months or whenever the prescription changes.

MEDICATION PERMISSION AND INSTRUCTIONS

CHILD CARE HOMES AND CENTERS

Department of Licensing and Regulatory Affairs

Bureau of Community and Health Systems

Child Care Licensing Division

If you are giving or applying any medication to a child in care, the following must be completed by the parent for **each** medication. An interruption in medication will require a new permission form.

TO BE COMPLETED BY PARENT

I give my permission for _____ to give or apply the medication
(Caregiver, Facility)

_____ , to my child _____ , as follows:
(Specify, prescribed medication/over the counter product) (Child's Name)

DIRECTIONS:

1. Date to Begin Giving Medication	2. Date to Stop Medication
3. Times Medication is to be Given	4. Amount (dosage) of Medication Each Time Given
5. Storage of Medication	
6. Other Directions, if Any	
Signature of Parent	Date

TO BE COMPLETED BY THE CAREGIVER GIVING THE MEDICATION:

DATE	TIME	AMOUNT GIVEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE

It is recommended this form be reviewed with the parent every 3 months if the medication is ongoing.

LARA is an equal opportunity employer/program.