MEDICATION ADMINISTRATION AUTHORIZATION FOR SELF-ADMINISTRATION/ SELF-POSSESSION

Michigan State Law requires that students self-administering medications must have written orders from the physician/licensed prescriber and written authorization from the parent/guardian. **"Self-administration"** means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. "**Self-possession"** means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate and self-determined administration.

PLEASE NOTE - **"Medication"** refers to any prescription, over-the-counter (OTC), homeopathic, herbal, vitamin, or mineral preparation.

Parents are urged to give medication at home and on a schedule outside of school hours, if possible. If it is necessary that medication be provided during school hours, these regulations must be followed:

- Medications must be prescribed in writing by a physician or other licensed prescriber and must be renewed at least annually.
- All medication must be brought to school in the original pharmacy or OTC container labeled with the name of the student, medication, strength, dosage, route and time(s) to be given.
- Medications and related equipment/supplies, as ordered, must be provided to the school by parent/guardian as needed.
- Any misuse of medication by a student that violates school policies, including sharing medication for any reason, will result in revocation of self-possession privileges and may result in a referral to law enforcement officials.

When applicable, only a one-day supply of medication should be carried. Families are encouraged to provide spare medication properly labeled in its original container to the school, in case the student runs out or forgets the medication. The building administrator may discontinue the student's self-possession privilege upon advanced notice to the parent/guardian. **The student must carry a copy of this form at school.**

In order for students to receive school-based services they must have current documentation of a medically based condition.

STUDENT'S NAME: _____ **DATE OF BIRTH:** _____

SCHOOL: _____ TEACHER: _____ GRADE: _____

TO BE COMPLETED BY THE PHYSICIAN:

Medication Name	Dosage	Route	Time & Frequency

Form of medication: ❑Tablet/capsule ❑Liquid ❑Inhaler ❑Injection ❑ Nebulizer ❑ Other _____

Special instructions/storage requirements: _____

Signs/Symptoms for which medication is being prescribed: _____

Restrictions and/or important Side effects: _____

Order Start Date: _____ Order End Date: _____

(If no end date is indicated, medication orders will expire at the end of the current school year).

Student is capable of and authorized to: ❑ self-administer the above medication ❑ self- possess the above medication

NOTE: To participate in Medicaid School Services Program, a valid prescription MUST be signed and dated by a physician or other licensed prescriber and include the prescriber's name, address, telephone number, and NPI number.

Signature: _____ Printed Name: _____

Date: _____ Phone: _____ Fax: _____ NPI #:_____

Address: _____

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby authorize trained school staff to administer the identified medication, ordered by the licensed prescriber, to the child above. I will not hold the Board of Education or its personnel responsible for complications related to the medication pursuant to P.A. 451 of 1976-S1178. When necessary, staff may contact the licensed prescriber regarding administration of the medication. I understand that I am responsible for transporting the medication to the child's school.

Student is capable of and authorized to: ❑ self-administer the above medication ❑ self- possess the above medication

Signature: _____ Relationship: _____Date: _____

TO BE COMPLETED BY THE STUDENT:

I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication. I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parent/guardian, and the privilege(s) of self-administration/ self-possession denied.

Signature: _____ Date: _____

Please return completed form to: _____ ***Fax:*** _____ ***Email:*** _____