MEDICATION ADMINISTRATION AUTHORIZATION FOR SELF-ADMINISTRATION/ SELF-POSSESSION

Michigan Law requires written orders from the treating physician/licensed prescriber and written authorization from the parent/guardian in order for students to self-administer and/or self-possess medications in the school setting**. "Self-administer**" means that the student may administer the ordered medication without additional direction or supervision from school staff. **"Self-possess"** means that the student may carry the ordered medication on his/her person to allow for immediate and self-determined administration. **"Medication"** refers to any prescription, over-the-counter (OTC), homeopathic, herbal, vitamin, or mineral preparation.

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

- Medication and, if applicable, an accompanying Emergency Action Plan must be prescribed in writing by the treating physician/licensed prescriber and must be renewed at least annually, generally at the start of each school year **and** any time medication or health needs change.
- Medication must be brought to school in the original pharmacy or OTC container labeled with the student's name and medication name, strength, dosage, route of administration, and time(s) to be given.
- Related equipment/supplies, as ordered, must be provided by the parent/guardian, as needed, for use in the school setting.
- 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 and, if applicable, a copy of the Emergency Action Plan while 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

PLEASE 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. *Stamped signatures are **not** valid for school-based services.*

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

TO BE COMPLETED BY THE STUDENT:

I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the identified 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 will be denied.

Signature: _____ Date: _____

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