HURON VALLEY CATHOLIC SCHOOL

AUTHORIZATION FOR MEDICATIONS TO BE ADMINISTERED AT SCHOOL

Michigan law requires a physician's written order **AND** parent/guardian signature of authorization for the administration of **ALL** medications.

Student Name _____ DOB _____ Grade _____ Date _____

Medication Name	Reason for Medication	Dose	Route	Time	Self Admin. Epi-Pen or Inhaler? (yes or no)

*Routes –oral(pill/capsule/chewable/liquid) –inhaled(nebulizer/inhaler) –topical(skin/ear/eye/nose) –injection, other

List special instructions if needed _____

_____

Start date (if not beginning of school year) _____ Stop date (if not end of school year) _____

Physician's Signature_____ Date _____

Physician's Printed Name _____

Physician's Address_____

Phone # _____ Fax # _____

Authorization of Parent/Guardian concerning the administration of all above medications by school personnel

1) No medications will be given without a physician's order (must be signed by the physician).

2) Prescription medication must be in a container labeled by the pharmacist or prescriber.

3) OTC medications must be contained in a labeled, original container.

4) No medications will be given without a parent/guardian signature.

5) Any change in prescription medication including a change in dosage or the discontinuation of the medication must be accompanied by a physician's order.

I hereby permit the school nurse or other person designated by the school administrator to administer medications as directed by the physician and/or myself to the above named student and will not hold the school or its personnel responsible for the complications related to the medication pursuant to P.A. 451 of 1976-S1178. I give permission for the school nurse to communicate with my child's physician regarding this medication if needed.

Parent Signature _____ Date _____

Revised 3/12/2025