

**Woodhaven-Brownstown School District**

**Medication Prescriber/Parent Authorization Form**

**Student:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Teacher:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **School Year:** \_\_\_\_\_

**To Be Completed by Physician/Licensed Prescriber:**

Medication Name	Dose	Time to be Given	Route*	Side Effects	Adverse Reaction
1					
2					
3					

\*Routes: Inhaled (Inhaler/Nebulizer) - Oral (pill/capsule/chewable/liquid) - Topical (Skin Application) - Topical Ear Drop - Injection - Other (List)

List minimal frequency between doses (Especially if PRN): \_\_\_\_\_

If PRN, List symptoms/conditions under which medication is to be given: \_\_\_\_\_

Reason for Medication (Optional): Medication 1: \_\_\_\_\_ Medication 2: \_\_\_\_\_ Medication 3: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Start Date (if not start of school year): \_\_\_\_\_ Stop Date (if not end of school year): \_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature** **Physician's Printed Name**  
 \_\_\_\_\_ **Date**

**To Be Completed by Parent/Guardian:**

I request and give permission for (Name of Child) \_\_\_\_\_ to receive the medication(s)/treatment (listed above) at school according to standard school district policy and for the physician and school district staff to share information to assist my child with medication needs. (schools require Parent/Guardian to bring medication in its original container)

\_\_\_\_\_  
**Parent/Guardian Signature** **Date**

## Self-Administration / Self-Possession

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. For medication other than inhalers, only that day's supply of medication is to be carried. The school district recommends that spare medication, properly labeled in its original bottle, be kept in the clinic/office in case the student runs out/forgets the medication. The building administrator may discontinue the student's self-administration privilege upon advance notice to the parent/guardian. **THE STUDENT MUST CARRY A COPY OF THIS FORM AT ALL TIMES AND THE MEDICATION MUST BE IN ITS ORIGINAL PACKAGE WITH A PROPER LABEL.** (Initial: \_\_\_\_\_)

SELF-ADMINISTRATION/POSSESSION IS DISCOURAGED AT THE ELEMENTARY LEVEL but will be permitted if deemed medically necessary due to chronic illness.

### **To Be Completed by Physician/Licensed Prescriber for Self-Possession/Administration Only:**

The student is capable of \_\_\_\_\_ self-administering \_\_\_\_\_ self-possessing the medication(s) prescribed on this document.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Printed Name

### **To Be Completed by Parent/Guardian for Self-Possession/Administration Only: (Sign only if physician approves)**

I request and give permission for my child \_\_\_\_\_ to: \_\_\_\_\_ self-administering \_\_\_\_\_ self-possessing the medication(s) prescribed on this document according to school district policy and for the physician and school district staff to share information regarding my child's medication needs.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

### **To Be Completed by Student for Self-Possession/Administration Only: (Sign only if physician and parent approve)**

I agree to:

1. Never share my medication with another person
2. Carry the medication in its original properly labeled prescriptive container
3. Take medication only at the prescribed time/frequency and dose
4. Carry a copy of this form with me and present it to school staff if asked.

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

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date