

MEDICATION AT SCHOOL GUIDELINES

In compliance with State of Michigan Law and policy of the Allen Park Schools' Board of Education, the following procedures are set forth in administration of medication at school.

The form entitled, "Permission to Administer Medication," (on reverse side) must be completed by a physician and the parent/guardian prior to the administration of any medication at school. This includes both prescription and over-the-counter medications such as aspirin/Tylenol, inhalers, antibiotics, eye drops, cough medicines, acne medications, etc. School personnel can not accept or dispense medications that do not follow the guidelines below:

1. The container must be labeled with the child's name, the doctor's name, the name of the medicine, dosage, and frequency of administering the medication. All prescribed medications will be dispensed through the school office except those outlined in the Policy.
2. Prescription medications for middle school students must be brought to the school by the parent in order for proper procedures to be established.
3. No dosage or time of administration changes should be instituted except by written instruction from the physician after the initial request.
4. Parental or guardian request/permission and physician's instructions should be renewed annually, or more often, if necessary.
5. Prescription and medication supply renewals are the responsibility of the parent/guardian.
6. Medication left over at the end of the school year should be picked up within one week by the parent/guardian or the school will appropriately dispose of the medication.
7. The school will not be responsible for dividing pills.
8. Middle School students may possess EpiPens and/or inhalers as well as appropriate non-prescription medications provided by their parents.
9. Students that carry EpiPens and/or inhalers must have this information reported on the "Student Information Form" that is mailed to parents at the beginning of the school year.
10. It is the responsibility of the parent to notify the school of any changes in medication status.

Please contact our office if you have questions or need further information about the administration of medications at school.

**ALLEN PARK PUBLIC SCHOOLS
PERMISSION TO ADMINISTER MEDICATION**

DATE FORM RECEIVED BY SCHOOL _____ SCHOOL NAME _____

STUDENT NAME _____

DATE OF BIRTH _____

GRADE _____ TEACHER (if applicable) _____

ATTENDING PHYSICIAN _____ PHONE _____

PHYSICIAN'S ADDRESS _____ FAX _____

MEDICATIONS: TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

1. NAME OF MEDICATION _____

DOSAGE _____ TIME OF ADMINISTRATION _____

REASON FOR MEDICATION _____

START DATE _____ STOP DATE _____ OTHER _____
(NOT TO EXCEED JUNE 16, 2010)

COMMENTS/POSSIBLE SIDE EFFECTS: _____

2. NAME OF MEDICATION _____

DOSAGE _____ TIME OF ADMINISTRATION _____

REASON FOR MEDICATION _____

START DATE _____ STOP DATE _____ OTHER _____
(NOT TO EXCEED JUNE 16, 2010)

COMMENTS/POSSIBLE SIDE EFFECTS: _____

IF THE MEDICATION PRESCRIBED IN NUMBER 1 AND/OR NUMBER 2 ABOVE INCLUDES THE USE OF AN INHALER AND/OR EPIPEN, THE PATIENT/STUDENT HAS MY APPROVAL TO POSSESS AND USE THE MEDICATION AS DESCRIBED IN NUMBER 1 AND NUMBER 2 ABOVE.

NOTE FOR PHYSICIAN: DEPENDING ON THE STUDENT'S GRADE LEVEL AND INDIVIDUAL CIRCUMSTANCES, YOU MAY WANT TO CONSIDER UP TO THREE (3) PRESCRIPTIONS AS FOLLOWS: 1ST, IF THE STUDENT REQUIRES THAT AN EPIPEN AND/OR INHALER BE LEFT ON HIS/HER PERSON (OR IN THEIR SCHOOL DESK AT ELEMENTARY LEVEL); 2ND, FOR BUS TRANSPORTATION, AND 3RD, FOR THE SCHOOL OFFICE.

DATE _____ PHYSICIAN'S SIGNATURE _____

TO BE COMPLETED BY PARENT:

I REQUEST THAT (NAME OF CHILD) _____ RECEIVE THE ABOVE MEDICATION AT SCHOOL ACCORDING TO STANDARD SCHOOL POLICY.

I HEREBY REQUEST THAT MY CHILD BE ADMINISTERED PRESCRIBED MEDICATION AT SCHOOL BY SCHOOL PERSONNEL. I UNDERSTAND THAT THE MEDICATION WILL BE ADMINISTERED EXACTLY AS PER THE DIRECTIONS OF MY ABOVE NAMED PHYSICIAN. I WILL NOTIFY THE SCHOOL OF CHANGES OR DISCONTINUATION OF THIS MEDICATION(S) BY COMPLETING A NEW FORM. IN THE EVENT THAT THE MEDICATION DESCRIBED IN NUMBER 1 AND/OR NUMBER 2 ABOVE IS PRESCRIBED FOR THE TREATMENT OF ASTHMATIC SYMPTOMS, I APPROVE THAT MY CHILD MAY POSSESS AND USE THE MEDICATION(S) AS DESCRIBED IN NUMBER 1 AND/OR NUMBER 2 ABOVE.

SIGNED _____ DATE _____
PARENT OR LEGAL GUARDIAN

ADDRESS _____ PHONE _____

