**Kenwood Elementary School**
**Phone: 248.655.3838**
**Fax: 248.655.3802**

Clawson Public Schools
AUTHORIZATION FORM FOR
**PRESCRIBED MEDICATION**
ELEMENTARY SCHOOLS
(one form per prescription)

**Schalm Elementary School**
**Phone: 248.655.4949**
**Fax: 248.655.4947**

## To be completed by the parent/guardian

Student: _____ Date of Birth: _____

Grade: _____ Age: _____ Teacher: _____

I request that _____ receive the prescribed medication at school according to standard school policy which I have read.

- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability, foreseeable or unforeseeable, for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent/Guardian: _____ Relationship: _____ Date: _____

## To be completed by the physician or authorized prescriber

Name of medication: _____

Reason for medication: (Optional) _____

Exact Dosage/Frequency: _____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Injection ☐ Other _____

___on person ___ in office

Instructions: _____

_____

Start Date: _____ Stop Date: _____

Restrictions and/or important side effects: _____

_____

Special storage requirements: ____None ____Refrigerate ____Other _____

Physician's Signature: _____ Date: _____

Physician's Name: _____

Address: _____

Phone Number: _____

# CLAWSON PUBLIC SCHOOLS
## PARENTAL RESPONSIBILITIES
## PRESCRIBED MEDICATION PROCEDURES
## ELEMENTARY SCHOOLS

1. The student's parent/guardian must provide the school with written permission and request to administer medication. (Please use attached form.)
2. Written instructions from the physician include name of student, name of medication, dosage, time to be administered, route of administration, and duration of administration **must** accompany the medication.
3. A separate authorization for medication from must be filled out for each medication.
4. Medication must be brought to school by the parent/guardian unless other safe arrangements are necessary and possible.
5. All prescription medication must be in a labeled container as prepared by a pharmacy and labeled with dosage and frequency of administration.
6. Parental/guardian requests/permission and physician's instructions must be renewed annually at a minimum.
7. Prescription and medication supply renewal is the responsibility of the parent/guardian.
8. Medication left over at the end of the school year will be picked up by the parent/guardian or the school will appropriately dispose of the medication, and record this disposal on the medication log. A second adult will witness disposal of medication.
9. The school has set designated time for administration of medication. Please inform your physician for when he/she writes instructions for administration of the medication.
10. It is the parent/guardian's responsibility to check expiration dates periodically, especially on epi-pens and inhalers.

Suggested Procedures for Student Self-Administration/Self Possession:

1. The student's parent/guardian must provide the school with written permission and request to administer medication.
2. Written instructions from the physician include name of student, name of medication, dosage, time to be administered, route of administration, and duration of administration **must** accompany the medication.
3. The student's parent/guardian must provide written permission and request to the school to allow student to self-possess and self-administer medication.
4. Written instructions, which include name of student, name of medication, dosage, time to be administered, route of administration, and duration of administration, and the physician/provider instructions that the student may self-possess and/or self-administer must be provided to the school.
5. The parental/guardian request/permission and physician's instructions must be renewed annually.
6. All medications should be kept in a labeled container as prepared by a pharmacy or pharmaceutical company and labeled with dosage and frequency of administration. This language also pertains to refills.
7. The building administrator may discontinue the student self-administration privilege upon advance notification to the parent/guardian.

**Please note that these procedures are in effect for prescription and non-prescription medications. They also apply even if the medication needs to be given only once or twice.**

# School Based Medical Disorder Management Plan

To be completed by Physician

Student Name: _____ Birth Date: _____ School: _____

Medical Disorder Type: _____

Date of last incident: _____

What happens during the incident? _____

_____

Warnings or behavior changes before incident occurs? _____

_____

Limitations in school related activities: _____

_____

Medications taken for condition (if any): _____

## ***ACTION FOR MINOR REACTION***

1. If symptom(s) are: _____

   **Physician's Instructions**: _____

   _____

2. Then call: Parent/Guardian: _____ Daytime phone number _____

   If unable to contact Parent/Guardian call:

   Emergency Contact: _____ Daytime phone number _____

## ***ACTION FOR MAJOR REACTION***

1. If symptom(s) are: _____

   **Physician's Instructions**: _____

   _____

   Then call: Parent/Guardian: _____ Daytime phone number _____

   If unable to contact Parent/Guardian call:

   Emergency Contact: _____ Daytime phone number _____

**Even when not included in instructions, staff may make a decision to call 911 for an emergency situation**

Physician's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____