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.

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:____