

CLARENCEVILLE SCHOOL DISTRICT
Administering Medicine to Students

Dear Parents and Physician:

It is the policy of the Clarenceville School District, in compliance with Michigan Compiled Laws Section 380.1178, to have written authorization for a student to take prescribed medication during the school day. This information will be handled in a confidential manner. Authorization is good for one school year only.

PARENT AUTHORIZATION

Student's Name _____

Date of Birth _____

School _____

Grade _____

Authorization is hereby granted school personnel to administer/provide medication to the above named student in accordance with the following physician's directive.

Signature of Parent/Legal Guardian _____

Date _____

PHYSICIAN AUTHORIZATION

Prescription(s)

1. Name of medication _____ Dosage _____
Reason for medication _____
To be given at _____ (state time/hour)
From _____ (date) to _____ (date)
Comments regarding medication (adverse reactions, precautions, etc.)

2. Name of medication _____ Dosage _____
Reason for medication _____
To be given at _____ (state time/hour)
From _____ (date) to _____ (date)
Comments regarding medication (adverse reactions, precautions, etc.)

In case of emergency call: _____

Signature of Physician _____

Date _____

Print name of physician _____

Address _____

Phone _____

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