Clawson High School
Phone: 248.655.4200
Fax: 248.655.4205

CLAWSON PUBLIC SCHOOLS
AUTHORIZATION FORM
FOR **PRESCRIBED MEDICATION**
SECONDARY SCHOOLS
(one form per prescription)

Clawson Middle School
Phone: 248.655.4250
Fax: 248.655.4251

Student:_____ Date of Birth:_____

Grade:_____ School:_____ Age:_____

To be completed by physicians or authorized prescriber

Name of medication:_____

Form of medication/treatment:

_____ Tablet/capsule _____ Liquid _____ Inhaler _____ Injection _____ Nebulize _____ Other

Medication will be administered as follows: **Before lunch or After Lunch (Circle one)**

Start: _____ date form received Other dates: _____

Stop: _____ end of school year Other date/duration: _____

Restrictions and/or important side effects: _____ None anticipated

_____ Yes, Please describe:_____

_____

Special storage requirements: _____ None _____ Refrigerate

This student is both capable and responsible for self-administering this medication:

_____ No _____ Yes-supervised _____ Yes-unsupervised

This student may carry this medication: _____ NO _____ YES

Physician's Signature: _____ Date: _____

Physician's Name (please print):_____

Address: _____

Phone No: _____

To be completed by parent/guardian

I request that _____ receive the above medication at school according to standard school policy, which I have read on the reverse side of this form.

I request that _____ be allowed to self-administer the above medication at school according to the school policy which I have read on the reverse side of this form.

- 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: _____ **Relationship:** _____ **Date:** _____

CLAWSON PUBLIC SCHOOLS
PARENTAL RESPONSIBILITIES
PRESCRIBED MEDICATION PROCEDURES
SECONDARY 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 Needs Management Plan

To be completed by Physician

Student Name: _____ Birth Date: _____ School: _____

Medical Disorder Type: _____

Date of most recent episode: _____

What happens during an episode: _____

_____

Warnings or behavior changes before an episode occurs? _____

_____

Medications taken for condition (if any): _____

_____

Recommended limitations in school-related activities: _____

_____

ACTION FOR MINOR REACTION

1. If symptom(s) are: _____

   Physician's Instructions: _____

   _____

To be completed by Parent

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: _____

   _____

To be completed by Parent

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

If unable to contact Parent/Guardian call:

Emergency Contact: _____ Daytime phone number _____

Note: Even when not included in instructions, school staff may make a decision to call 911 in what is believed to be an emergency situation.

Physician's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

School Representative Signature _____