

MARQUETTE AREA PUBLIC SCHOOLS
PERMISSION FORM FOR PRESCRIPTION/NON-PRESCRIPTION MEDICATION (K-12)

Student's Name _____ DOB _____ Grade _____ Teacher/Homeroom _____

The Michigan State Law, 1979 P.A. 451 states:

380.1178. Administration of Medication to Pupil; Liability

Sec. 1178. School administrator, teacher, or other school employee designated by the school administrator, who in good faith administers medication to a pupil in the presence of another adult pursuant to written permission of the pupil's parents or guardian and in compliance with the instructions of a physician is not liable in a criminal action or for the civil damages as a result of the administration except for an act of omission amounting to gross negligence or willful and wanton misconduct.

The Board policy of Marquette Area Public Schools Section 378-340 (Policy 3025) provides that administration of medication (prescription/non-prescription) in school must be on the basis of written permission by the parent or guardian, must be done in compliance with a physician's instructions, and done in the presence of another adult.

Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent/guardian requests for the dispensing of necessary prescribed medication to students for limited periods of time.

The **MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION CONTAINER** clearly labeled with the name of the student; name and dosage of the medication, method of dispensation; time of day to be given, name of physician; date issued, pharmacy name, address, and phone number. **ALL MEDICATION FOR STUDENTS K - 12 MUST BE BROUGHT TO THE SCHOOL BY A PARENT OR DESIGNATED ADULT.** If these guidelines are not followed the medication will **NOT** be given.

OVER THE COUNTER MEDICATIONS WILL NOT BE DISPENSED without written permission by the student's parent/guardian **AND** the instructions and signature of a physician.

TO BE COMPLETED BY PARENT/GUARDIAN

I request that (name of child) _____ receive the medication listed below at school according to the standard school policy.

Signature _____ Relationship _____ Date _____ Phone _____

I understand that it is the sole responsibility of my child to report to the office for his/her medication(s). I also understand that it is my responsibility to notify the school of change or discontinuation of the medication(s).

On shortened school days, dispensing of medication will be the responsibility of the parent.

By law, any unused, discarded or outdated medicine must be picked up by the parent/guardian within seven (7) days of notification by school authorities or the medication must be destroyed by school personnel.

TO BE COMPLETED BY THE PHYSICIAN/AUTHORIZED PRESCRIBER

Name of medication _____

Reason for medication (OPTIONAL) _____

Form of medication/treatment ___ Tablet/capsule ___ Liquid ___ Inhaler ___ Injection ___ Other

Instructions (schedule and dose to be given at school) _____

Start Date form received _____ Other dates _____

Stop End of school year _____ Other date/duration _____

Instructions in case of missed dosage _____

Restrictions and/or important side effects _____ None anticipated _____

Yes, please describe _____

Physician's Name _____

Address _____ Phone _____

Date _____ Signature _____

Date Form Received by the School _____