Jonesville Community Schools

AUTHORIZATION FOR ROUTINE/SHORT TERM MEDICATION ADMINISTRATION

Michigan State Law requires that a written medication order of an authorized prescriber and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated staff member to administer medication. Teachers cannot keep any medication in their rooms. Students are to bring all medicine to the school nurse in the ***current prescription bottle with the doctor's instructions*** *before the school can administer it. The school cannot dispense aspirin, cold remedies, or other nonprescription medication unless you send it from home with a note, which indicates precisely how you wish to have it dispensed.* ***All medications are to be sent in the original container."***

This policy will be strictly enforced. Most pharmacies will provide a bottle for home and for school if necessary. **It is preferred that parents bring medication in to the school rather than send it to school with the student.**

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE MEDICATIONS IN SCHOOL. PLEASE FILL IN **ALL** AREAS.

Name of Student _____ Date of Birth _____ Teacher/Grade _____

Please administer to the above named student the following medication:

Medication(What?) _____ Dosage (How much?) _____ Route (How is it given?) _____

Time of day to be given **at school** _____ Reason for Medication(Why is it being given?) _____

Date to be started **at school** _____ Stop Date _____

Prescribing Physician's Name _____ Prescribing Physician's Phone &/or Fax _____

Restrictions and/or adverse reactions: ❒None Anticipated ❒Yes Please explain: _____

Special Storage Requirements: ❒None ❒Refrigerate ❒Other _____

I hereby request Jonesville Community Schools to supervise the medication routine and administration prescribed for my child. I have read the school's policy and regulations pertaining to administration of medication.

1. I agree to follow the school's policy and regulations regarding medication administration.
2. I will assume responsibility for use of medication in school, either by me or by my child.
3. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
4. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or in-directly from this authorization.
5. I give permission for the school to contact the above named physician and exchange information regarding this medication.

❒ Please send a note ❒ Please call _____(phone number) when getting low or out of medication.

Signature of Parent/Guardian _____ Date _____

Physician's Orders (please have physician complete and fax to school 517/849-7306): _____

Physician's Signature _____ Date _____

MEDICATION COUNT RECORD
(For School Use Only)

Student_____ **Teacher**_____

Medication	Strength	Route	Start Date	Last Dose	Initial Count

R=received B=balance of medication on hand IN-initials

Date	Aug			Sep			Oct			Nov			Dec			Jan			Feb			Mar			Apr			May			Jun		
	R	B	IN	R	B	IN	R	B	IN	R	B	IN	R	B	IN	R	B	IN	R	B	IN	R	B	IN	R	B	IN	R	B	IN	R	B	IN
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DC=discontinue W=dose withheld N=no med D=dismissal A=Absent F=Field Trip O=no show X=no school

Nurse's Full Name	*Initials*	*Nurse's Full Name*	*Initials*

Comments: