SPARTA AREA SCHOOLS

Medication Authorization Form

Student Name: _____ **Date of Birth:_____**

School:_____ **Grade:_____**

Medication Policy Reminders:

Michigan Law requires written orders from the treating physician/licensed provider and written authorization from the parent/guardian in order for school staff to administer medications to students in the school setting.

"Medication" refers to any prescription, over-the-counter (OTC), homeopathic, herbal, vitamin, or mineral preparation.

1. Medications cannot be administered to a student without written permission from a parent or guardian AND physician/licensed provider and must be updated annually and when a medication change is made.
2. All medications must be brought to school by a parent or guardian.
3. All medications must be in the original container and appropriately labeled. School personnel cannot administer unlabeled medications.
4. No medications are to be kept with the student except those required for asthma, allergic reaction, diabetes, or seizure disorders. Specific authorization forms must be filled out for Inhalers, Epipens, Glucagon, and emergency seizure medications.
5. The parent or guardian must pick up unused medications. No medications will be stored over the summer. Remaining medications will be disposed of properly at the conclusion of the school year.

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER:

Medication Name	Dosage	Route	Frequency

Form of Medication (circle one): Tablet/capsule Liquid Inhaler Injection Other_____

Special Instructions/storage requirements:_____

Signs/symptoms for which medication is being prescribed:_____

Restrictions and/or side effects:_____

Order start date:_____ Order end date:_____

Please Note:
To participate in Medicaid School Services Program, a valid prescription MUST be signed and dated by a physician/licensed prescriber and include the prescriber's name, address, telephone number, and NPI number. Stamped signatures are not valid for school-based services.

Provider Signature:_____ Date:_____

Printed Name:_____ NPI #:_____

Address:_____

Phone Number:_____ Fax:_____

TO BE COMPLETED BY THE PARENT/GUARDIAN: I request that the named student receive the above medication at school according to standard school policy and for the physician/provider and school staff to share information needed to assist my child with his/her health and medication needs. I will notify the school immediately if there is any change in the use of the medication or treatment. I release and agree to hold the Board of Education and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____ _____

Parent/Guardian Signature Printed Name Date