SPARTA AREA SCHOOLS • SPARTA, MI

Medication Administration in School

Parent Responsibility

Parents are urged to give medications at home, prior to and after school hours if possible. If this is not possible, please review the information in this brochure and complete the required form(s).

The State of Michigan requires a parent/guardian signature AND a licensed provider signature on a Medication Authorization Form for all medications administered at school. This includes prescription and over-the-counter medications and applies to daily, as-needed and/or emergency use medications. Any changes must be in writing from the prescriber.

Who is a licensed prescriber?

Physician (MD or DO)
Physician Assistant (PA)
Nurse Practitioner (NP)
Dentist (DDS)

What is self-carrying and self-administration?

In order for a student to self-possess (carry medication with them) and self-administer (give themselves medication), the student must have a Medication Authorization Form AND a Medication Authorization Self-Administration and Self-Possession Form signed by a provider and parent.

Where do I get these forms?

Please see pages 2 & 3 for attached forms. Printed forms can be obtained from your student's school office.

For your convenience, we encourage you to utilize your child's electronic medical chart through their physician for proper signature and approvals.

A note about alternative medicine:

School staff members are not authorized to administer complementary or alternative remedies. This includes naturopathy, homeopathy, dietary supplements, essential oils, and herbal remedies. These substances are not regulated by the FDA, therefore the labeling, potency, and purity cannot be guaranteed.

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Questions? Please contact your student's building:

Ridgeview: P (616) 887-8218
F (616) 887-1928

Appleview: P (616) 887-1743
F (616) 887-7509

Middle School: P (616) 887-8211
F (616) 887-1080

High School: P (616) 887-8213
F (616) 887-1264

Dropping off Medication

All medications must be dropped off by a parent/legal guardian. Students are not permitted to drop off medications.
All medications must be received in their original pharmacy container with a current pharmacy label showing:

- ☐Name of the Student
- ☐Medication
- ☐Dosage
- ☐Time(s) to be given

Non-prescription medication must also be in its original packaging. School staff will not administer unlabeled medication.

All Medications must be picked up by a parent/legal guardian at the end of the year or they will be disposed of 1 week after school ends.

*** Over-the-counter, FDA-approved topical medications do not require a provider's signature if the student is able to apply it themselves.

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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

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Medication Administration Authorization Self-Administration/Self-Possession Form

Michigan State Law requires that students self-administering medications must have written orders from the physician/licensed prescriber and written authorization from the parent/guardian. **"Self-administration"** means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. **"Self-possession"** means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate and self-determined administration.

- Medications must be prescribed in writing by a physician or other licensed prescriber and must be renewed at least annually.
- All medication must be brought to school in the original pharmacy or OTC container labeled with the name of the student, medication, dosage, route and time(s) to be given.
- Medications and related equipment/supplies, as ordered, must be provided to the school by parent/guardian as needed.
- Any misuse of medication by a student that violates school policies, including sharing medication for any reason, will result in revocation of self-possession privileges and may result in a referral to law enforcement officials.

STUDENT'S NAME:_____DATE OF BIRTH:_____

SCHOOL:_____TEACHER:_____GRADE:_____

TO BE COMPLETED BY THE PHYSICIAN:

Medication Name	Dosage	Route	Time and Frequency

Form of medication: ❑Tablet/capsule ❑Liquid ❑Inhaler ❑Injection ❑ Nebulizer ❑ Other_____

Special instructions/storage requirements:_____

Signs/Symptoms for which medication is being prescribed:_____

Restrictions and/or side effects:_____

Order Start Date:_____Order End Date:_____

Student is capable of and authorized to: ❑ self-administer the above medication ❑ self-possess the above medication

NOTE: To participate in Medicaid School Services Program, a valid prescription MUST be signed and dated by a physician or other licensed prescriber and include the prescriber's name, address, telephone number, and NPI number.

Provider Signature:_____Printed Name:_____

Date:_____ Phone:_____Fax:_____NPI #:_____

Address:_____

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby authorize trained school staff to administer the identified medication, ordered by the licensed prescriber, to the child above. I will not hold the Board of Education or its personnel responsible for complications related to the medication.

Student is capable of and authorized to: ❑ self-administer the above medication ❑ self-possess the above medication

Signature: _____ Date: _____

TO BE COMPLETED BY THE STUDENT: I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication. I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parent/guardian, and the privilege(s) of self-administration/self-possession denied.

Signature: _____ Date: _____