

Ypsilanti Community Schools
AUTHORIZATION FOR MEDICATION
DURING SCHOOL HOURS
School Year 2023-2024

Student Information

Student Name _____ Birth Date _____
School Building _____ Teacher _____ Grade _____

Medication Information

Diagnosis or Reason for Medication _____

Medication and Dosage _____

Form: Tablet Capsule Liquid MD Inhaler Nebulizer Ointment Other _____

Amount to be Given _____ Route: Oral Injection Rectal Inhaled Other _____

Time of Administration _____

Important Side Effects: None anticipated Yes (describe) _____

Special storage requirements: None Refrigerate Other _____

Start: Date form received _____ Other date _____
Stop: End of school year Other date _____ (Note: permission must be renewed each school year)

Important Notice to Parent and Physician:

1. Self-carried means the student will possess and self-administer the medication without supervision. Controlled substances are not allowed to be self-carried. Physician and parent authorization is required and no records are kept by the school.
2. Medication stored by the school for the student, even if self-administered, must have both physician and parent authorization. Records will be kept by the school of each dose taken.

Physician Authorization

- School personnel will administer this medication
----- OR -----
- This student is capable of and may self-administer this medication under the supervision of school personnel.
----- OR -----
- This student is capable of and may carry and self administer this medication (No controlled substances).

Physician's Name _____
(please print)

Physician's Signature _____

Date _____

Phone # _____ FAX# _____

Parent/Guardian Authorization

- School personnel will administer this medication.
----- OR -----
- This student is capable of and may self-administer this medication under the supervision of school personnel.
----- OR -----
- This student is capable of and may carry and self-administer this medication (No controlled substances).

Therefore, I understand and agree to accept:
*any risk that the medication may be lost or stolen,
*that the student may misuse the medication,
*that the school will not keep any record of the dates or times of medication administration,
*that this privilege will be revoked if problems arise from inappropriate use.

Parent/Guardian's Signature _____

Date _____

Home Phone # _____ Work # _____

School Acceptance (needed only for self-administered/self-carried medication)

Student has demonstrated safe self-administration of medication. Yes No

School Nurse's Signature _____ Date _____ Building Principal's Initials _____