

Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

LIVONIA PUBLIC SCHOOLS

15125 FARMINGTON ROAD, LIVONIA, MI 48154

**MEDICATION AUTHORIZATION**

STUDENT'S NAME	DATE OF BIRTH	TODAY'S DATE
SCHOOL	TEACHER/COUNSELOR	GRADE

Both prescription and nonprescription medications require a completed Medication Authorization form signed by a physician and parent/guardian. If medication is related to a life-threatening health condition, Livonia Public Schools staff will develop an Individualized Health Care Plan in conjunction with the student's physician.

**TO BE COMPLETED BY THE PHYSICIAN:**

NAME OF MEDICATION		<input type="checkbox"/> Prescription <input type="checkbox"/> Non-Prescription
REASON FOR MEDICATION		
FORM OF TREATMENT: <input type="checkbox"/> Tablet/Capsule <input type="checkbox"/> Inhaler <input type="checkbox"/> Liquid <input type="checkbox"/> Injection <input type="checkbox"/> Nebulizer		
INSTRUCTIONS		
DOSAGE:	TIME OF DAY: <input type="checkbox"/> Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Emergency Only <input type="checkbox"/> Other	
IF DOSAGE IS "AS NEEDED" OR "EMERGENCY ONLY" SPECIFY SYMPTOMS AND LIMITS:		
RELEVANT SIDE EFFECTS.		
STORAGE REQUIREMENTS: <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other	STUDENT IS CAPABLE AND RESPONSIBLE FOR SELF-POSSESSION AND SELF-ADMINISTERING <input type="checkbox"/> Inhaler <input type="checkbox"/> Emergency	
PLEASE INDICATE IF YOU HAVE PROVIDED ADDITIONAL INFORMATION <input type="checkbox"/> On the back of this form <input type="checkbox"/> As an attachment		
PHYSICIAN'S NAME	PHONE	FAX
ADDRESS		
PHYSICIAN'S SIGNATURE		DATE

**TO BE COMPLETED BY THE PARENT/GUARDIAN**

I request that \_\_\_\_\_  
Student's Name

Receive the above Medication at school according to district policy  
Be allowed to self-administer the above medication (Inhaler or emergency medication) at school according to district policy

I authorize school personnel to contact the above physician with questions or concerns relative to this authorization and medication

Parent/Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_

**\*NOTES**

- 1.) Medication includes prescription, non-prescription and herbal medications, and includes those taken by mouth, by inhaler, those that are injectable, and those applied as drops to eyes, nose, or medications applied to the skin.
- 2.) Medications must be in an appropriately labeled container
- 3.) This authorization is valid for the current school year only
- 4.) This authorization must be maintained with the Individual Student Medication Log
- 5.) It will be the student's responsibility to make contact with school personnel for the administration of medication, unless other arrangements have been made by the administrator

Revised 06/07