

**Medication Authorization**

Student's Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ 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.**

<i>TO BE COMPLETED BY THE PHYSICIAN</i>	
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 Meds	
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 _____
Address _____ _____	Fax _____
Physician's Signature _____	Date _____

*TO BE COMPLETED BY THE PARENT / GUARDIAN*

I request that \_\_\_\_\_  receive the above medication at school according to district policy.  
Student's Name

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.