

# 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. Medications CANNOT be dropped off until this form is completed and on file with your child's school office.
3. All medications must be brought to school by a parent or guardian.
4. All medications must be in the original container and appropriately labeled. School personnel cannot administer unlabeled medications. **All medication brought to school must match the information indicated by the Provider below.**
5. No medications are to be kept with the student except those required for rescue conditions. Please fill the **Medication Administration Authorization Self-Administration/Self-Possession Form** if the student requires self-carry rescue medications (i.e., inhalers, Epinephrine, diabetic supplies and seizure rescue medications).
6. 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.
7. If your child is Medicaid eligible, school health services may be billed on behalf of the school. School district billing will not impact future benefits of your family's Medicaid plan.

**TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER (MUST fill in Dosage – CANNOT say "See box/OTC" without specific measurement and Frequency; CANNOT say "As needed" or "PRN" without specific timeframe):**

Medication Name	Dosage (Specific measurement)	Route	Frequency (Specific timeframe)

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 the 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. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA. 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