SPARTA AREA SCHOOLS

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 (**this only includes Rescue Inhalers, Epinephrine, Diabetic Supplies and Rescue Seizure Medications**). **"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 administration (**this means that the student is responsible for carrying/administering the medication during school hours including field trips**).

- **By signing this form, you are giving Student permission to Self-Carry and Self-Administer medications. If for any reason the student cannot Self-Administer medication, trained staff will administer the medication for them.**
- Medications must be prescribed in writing by a physician or other licensed prescriber and must be renewed at least annually.
- All medication brought to school must match the information indicated by the Provider below.
- 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.
- 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.

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:_____

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:

Where is your child keeping their emergency Medication (please be specific i.e., "outside, front pocket of backpack")?

_____

I hereby authorize my child to administer the identified medication, ordered by the licensed prescriber. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA. I will not hold the Board of Education or its personnel responsible for complications related to the 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: _____