CLARENCEVILLE SCHOOL DISTRICT
Administering Medicine to Students

Dear Parents and Physician:

It is the policy of the Clarenceville School District, in compliance with Michigan Compiled Laws Section 380.1178, to have written authorization for a student to take prescribed medication during the school day. This information will be handled in a confidential manner. Authorization is good for one school year only.

PARENT AUTHORIZATION

Student's Name ______________________ Date of Birth ______________________

School ______________________ Grade ______________________

Authorization is hereby granted school personnel to administer/provide medication to the above named student in accordance with the following physician's directive.

Signature of Parent/Legal Guardian ______________________ Date ______________________

PHYSICIAN AUTHORIZATION

Prescription(s)

1. Name of medication ______________________ Dosage ____________
   Reason for medication ______________________
   To be given at ______________________(state time/hour)
   From ____________ (date) to ____________(date)
   Comments regarding medication (adverse reactions, precautions, etc.)
   ____
   ____

2. Name of medication ______________________ Dosage ____________
   Reason for medication ______________________
   To be given at ______________________(state time/hour)
   From ____________ (date) to ____________ (date)
   Comments regarding medication (adverse reactions, precautions, etc.)
   ____
   ____

In case of emergency call: ______________________

Signature of Physician ______________________ Date ______________________

Print name of physician ______________________ Address ______________________ Phone ______________________

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