26275 Northwestern Hwy Southfield, MI 48076 (248) 301-9909

# AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student Last Name: _____First Name: _____

Date of Birth: _____ Grade _____ Teacher(s) _____

***Physician's Order (must be completed by physician or authorized prescriber)***

Diagnosis/Purpose of Medication: _____

Name of Medication: _____ Dosage: _____

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other_____

This prescription is: _____Initiation of Therapy _____ Adjustment of Dosage

_____Maintenance Dose _____ Discontinuation of Therapy

Important side effects or restrictions: _____

Start: Date form received _____ Other dates: _____

Stop: End of school year _____ Other date/duration: _____

☐ For episodic/emergency events only

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

This student is both capable and responsible for self-administering this medication

☐ No ☐ Yes-Supervised ☐ Yes-Unsupervised Student may carry this medication: ☐ No ☐ Yes

Physician's Signature:_____Phone:_____ Date:_____

Physician's Name: _____Address:_____

The undersigned parents/guardians authorize Faxon Academy, through its office staff, building level principal/secretary, to administer medication or to supervise the taking of medication by my child. It is understood that the undersigned parent/guardian shall immediately notify the school district in writing in the event the prescription shall be discontinued or modified. The medication must be brought to school by the parent/guardian in the original pharmacy bottle, appropriately labeled. The medicine must be kept locked in the school office. Refill of the prescription shall be the responsibility of the parent/guardian. Further, the undersigned releases the school district and shall indemnify said school district from any liability or damage which may result to the student from a administration of said medicines as prescribed by physician.

Parent/Guardian Signature:_____Date:_____

Home Phone: _____Daytime Phone:_____