WEST BLOOMFIELD SCHOOL DISTRICT

Permission Form for Prescribed or Over the Counter Medication
Including Self-Administration and Self-Possession of Medications

ELEMENTARY AND SECONDARY

Dear Parents and Physician:
It is the policy of the West Bloomfield School District, in compliance with Michigan Compiled Laws Section 380.1178, to have written authorization for a student to take prescribed or over the counter medication during the school day. This information will be handled in a confidential manner. Authorization is good for one school year only.

Student _____ School _____
Date of birth, or age: _____ Date form received by the school: _____
Grade _____
Administrator approval for self-administration ☐ self-possession ☐
Administrator signature _____ Date _____

To be completed by the physician or authorized prescriber
Name of medication: _____
Reason for medication: (OPTIONAL) _____
Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection
☐ Nebulizer ☐ Other _____
Instructions (schedule and dose to be given at school): _____
_____
Start: ☐ date form received Other dates: _____
Stop: ☐ end of school year Other date/duration: _____
☐ For episodic/emergency events only
Restrictions and/or important side effects: ☐ None anticipated
☐ Yes. Please describe: _____

Special Storage requirements: ☐ None ☐ Refrigerate
Other _____

This student is both capable and responsible for self-administering this medication: ☐ No ☐ Yes-supervised ☐ Yes-Unsupervised
This student may carry this medication: ☐ No ☐ Yes
Please indicate if you have provided additional information: ☐ On the back of this form ☐ As an attachment

Physician's Signature _____ **- Date** _____

Physician's Name _____
Address _____
_____
Phone Number ( ) _____ **Fax Number** _____

To be completed by parent/guardian

I request that _____ receive the above medication at school according to standard school policy.
Name of child

I request that _____ be allowed to self-administer the above medication at school according to the school policy. *
Name of child

I request that _____ be allowed to self-possess the above medication at school according to school policy. *
Name of child

* NOTE: Elementary students must have an active IEP or Section 504 Plan to self-administer and self-possess medication.

Date: _____ Signature: _____ Relationship: _____