Garden City Public School
1851 W. Radcliff
Garden City, MI 48135
School District Telephone Number: 734-782-8300
School District Fax Number: 734-762-8532

ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Michigan State Law requires that schools dispensing medications (prescription or over-the-counter drugs) must have written orders from the physician and the written authorization of the parent/guardian. **In order for students to receive school based services they must have current documentation of a medically based condition.**

STUDENT'S NAME: _____ DATE OF BIRTH: _____

SCHOOL: _____ TEACHER: _____ GRADE: _____

TO BE COMPLETED BY THE PHYSICIAN:

Name of Medication(s)	Dosage	Time to be Administered
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special storage instructions: Refrigerate _____ None _____

Form of medication/treatment: ❑Tablet/capsule ❑Liquid ❑Inhaler ❑Injection ❑ Nebulizer ❑ Other _____

Conditions for which medication is being prescribed: _____

Restrictions and/or important side effects: _____

Physician's additional comments: _____

Order Start Date: _____ Order End Date: _____

(If no end date is indicated, medication orders will expire at the end of the current school year).

NOTE: To participate in Medicaid School Based Services, a valid prescription MUST be signed by a physician and include the date prescription was signed by physician, physician's name, address, telephone number and NPI number. *Stamped signatures and prescriptions signed by a nurse practitioner or physician assistant are invalid for school based services.*

Physician's Signature: _____ Date: _____

Print Physician's Name: _____ NPI # _____

Address: _____

Phone: _____ Fax: _____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that school personnel give my child _____ the medication ordered above by the physician and will not hold the Board of Education or its personnel responsible for complications related to the medication pursuant to P.A. 451 or 1976-S1178. Staff may contact the physician regarding administration of the medication if necessary. I am responsible for transporting the medication to my child's school.

Signature: _____ Relationship: _____ Date: _____

Please return completed form to: _____ ***Fax:*** _____