

DETROIT ACADEMY OF ARTS & SCIENCES SCHOOL DISTRICT

PHYSICIAN PERMISSION TO ADMINISTER MEDICATION

Pursuant to the MDE Model Policy for Administering Medications to Pupils at School as adopted by Detroit Academy of Arts and Sciences, "medication" includes prescriptions, non-prescriptions and herbal medications and includes those taken by mouth, by inhaler, those that are injectable, and those applied as drops to eyes, nose, or medication applied to the skin. For the purposes of this policy, the term "physician" means any health care provider licensed by the State of Michigan to prescribe medication.

Student Name _____

Grade _____ Date of Birth _____

Parent/Guardian Name _____

Contact # _____

**To be completed by the physician or authorized prescriber **

Name of Medication _____

Form of Medication/Treatment:

Tablet/Capsule Liquid Injection Nebulizer Cream Inhaler Other

Reason for Medication _____

Instructions: (schedule and dose to be given at school): _____

Start: Date form received Other dates: _____

Stop: End of the school year Other dates/duration: _____

For emergency/episodic events only

Restrictions and/or important side effects: None anticipated

Yes, please describe: _____

Special storage requirements: None Refrigerate Other: _____

This student is both capable of self-administering this medication:

No Yes, supervised Yes unsupervised

This student may carry this medication: No Yes

I give permission to the school district to administer prescription medications prescribed by me or other members of my practice to the student above per the instructions listed on the original packaging for the prescription medication.

Physician Name _____ Telephone Number _____

Physician Signature: _____ Date _____