SUPERIOR CENTRAL SCHOOLS

P.O. Box 148 Eben Junction, MI. 49825 Ph: (906) 439-5532 EL Fax: (906) 439-5734 HS Fax: (906) 439-5243

FORM FOR PRESCRIPTION/NON-PRESCRIPTION MEDICATION

Authorization for the Administration of Medicines by School Personnel

To be completed by Physician and Parent

2023-2024

****FORM MUST BE SIGNED BY A PHYSICIAN FOR BOTH PRESCRIPTION AND NON/PRESCRIPTION MEDICATION. THIS FORM WILL NOT BE ACCEPTED WITHOUT A PHYSICIAN'S SIGNATURE.**

Student _____ Date of Birth _____ Grade _____Teacher_____

Name of medication _____ Reason for medication _____

Form of medication: ____ Tablet/Capsule ____ Liquid _____ Inhaler ____ Injection ____ Nebulizer _____ Other

Dosage _____ Time(s) of administration _____

Length of time medication shall be administered: From: _____ to _____
Date Date

Restrictions/side effects: ____ None anticipated ____ Yes, please describe _____

Inhalers or Epi-pen only :This student may carry this medication: (inhalers only) ____No ____Yes ____n/a
The student is both capable and responsible for self-administering this medication
____ No ____ Yes – supervised ____ Yes – unsupervised

Please indicate if you have provided additional information _____ Back of form _____ Attachment

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Physician Name _____ Physician Signature: _____

Address _____

Phone Number _____

Parent/Guardian Authorization

I hereby request that school personnel give my child the medication ordered by the above physician**. I understand that it is the responsibility of my child to report to the office for his/her medication. I also understand that it is my responsibility to notify the school of change or discontinuation of this medication.**

DATE _____ SIGNATURE _____ RELATIONSHIP _____

Address _____

Home Phone _____ **Work Phone** _____

Student _____ **Date** _____