Lincoln Consolidated Schools
Administration of Medications by School Personnel

Michigan law requires a physician's written order along with the parent/guardian signature of authorization of administration of ALL medications.

Student Name _____________________________________________________________
DOB ____________ Grade __________________  Date ___________________________
School Year  20______- 20 ______

Medication: ______
Prescribed _________Unprescribed _______

*CHECK ONE

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<thead>
<tr>
<th></th>
<th>Medication</th>
<th>Dose</th>
<th>Time given</th>
<th>Route*</th>
<th>Side Effects</th>
<th>Self Admin. Epi-Pen or Inhaler?</th>
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*Routes - oral (pill/capsule/chewable/liquid) - inhaled (nebulizer/inhaler) - topical (skin/ear/eye/nose) - injection, other

List special instructions if needed _________________________________________________________

Special Storage Instructions:  none_________ refrigerate _______________

The student is both capable and responsible for self-administering medication: no _____
yes-supervised _____  yes-unsupervised _____

Start date (if not beginning of school year) ___________ Stop date (if not end of school year) _________

Physician name __________________________ Phone ________________ Fax __________________

Physician Address ____________________________________________________________________

Physician Signature ________________________________________________________________ Date _________________________

*REQUIRED IF IT’S PRESCRIBED MEDICATION

Authorization of Parent/Guardian concerning the administration of all above medications by school personnel

1) No medications will be given without a physician’s order (must be signed by the physician).
2) All prescription bottles must be labeled by the pharmacy with a current date, student name, medication name and medication strength
3) OTC medications must be contained in a labeled, original container.
4) Medication in the container must be the same medication stated on the label.
5) No medications will be given without a parent/guardian signature.
6) Any change in prescription medication including a change in dosage or the discontinuation of the medication must be accompanied by a physician’s order.

__________________________  _______________________
Parent/Guardian Signature Date