DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT
Students Rise. We All Rise.

PERMISSION FORM FOR PRESCRIBED MEDICATION

School Name:	Date Received:
Student Name:	Date of Birth: / /
Grade:	Teacher / Classroom:

TO BE COMPLETED BY PHYSICIAN

Name of Medication (List only 1 medication per form): _____

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions *(Dosage of medication and time to be administered)*: _____

☐ For episodic/emergency events only Comment: _____

Conditions for which medication is being prescribed: _____

Restrictions and/or important side effects: ☐ None anticipated ☐ Yes, please describe: _____

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)

Special storage instructions: ☐ 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 (Treatment Plan)

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:	Print Physician's Name:	NPI #:	Date:
Address:		Telephone:	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, including those administered pursuant to P.A. 451 of 1976, section 1178. Staff may contact the physician regarding administration of the medication if necessary. I am responsible for transporting the medication to my child's school.

I hereby request that school personnel would allow my child _____ to self-administer medication ordered above by the physician and will not hold the Board of Education or its personnel responsible for complications related to the taking of such medication. Staff may contact the physician regarding administration of the medication if necessary. I am responsible for transporting the medication to my child's school.

Parent or Guardian Signature	Print Name	Date
Relationship to student:	Telephone Number:	