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: |

## AUTORIZACIÓN DEL PADRE / TUTOR

Por la presente solicito que el personal de la escuela le dé a mi hijo(a) _____ el medicamento ordenado anteriormente por el médico y no responsabilizaré a la Junta de Educación ni a su personal por las complicaciones relacionadas con el medicamento, incluidas las administradas de conformidad con P.A. 451 de 1976, sección 1178. El personal puede contactar al médico con respecto a la administración del medicamento si es necesario. Soy responsable de transportar el medicamento a la escuela de mi hijo(a).

Por la presente solicito que el personal de la escuela permita que mi hijo(a) _____ se administre el medicamento ordenado anteriormente por el médico y no responsabilizaré a la Junta de Educación ni a su personal por complicaciones relacionadas con la toma de dicho medicamento. El personal puede contactar al médico con respecto a la administración del medicamento si es necesario. Soy responsable de transportar el medicamento a la escuela de mi hijo.

| Firma del Padre o Tutor | Nombre Escrito | Fecha |
|---|---|---|
| Relación con el Estudiante: | Teléfono: | |