YPSILANTI COMMUNITY SCHOOLS

Authorization for Medication During School Hours

Complete one form for each medication. Authorization must be renewed each school year.

SCHOLAR INFORMATION

Scholar Name

Birth Date

School Building

Grade

Teacher / Homeroom

Parent / Guardian Name

Home Phone

Cell / Work Phone

MEDICATION INFORMATION

Diagnosis / Reason for Medication

Medication Name

Dosage / Amount to Be Given

Time / Frequency of Administration

Form

☐ Tablet ☐ Capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Ointment **Other**

Route

☐ Oral ☐ Injection ☐ Inhaled **Other**

Start Date

Stop Date (or end of school year)

Possible Side Effects

Purpose of Medication / Treatment

Special Storage

☐ None ☐ Refrigerate **Other**

Additional Instructions

PHYSICIAN / LICENSED HEALTH CARE PROVIDER AUTHORIZATION

Provider Name (print)

Provider Phone

Fax

Office / Practice

Provider Signature (type name if electronic)

Date

YPSILANTI COMMUNITY SCHOOLS

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Parent/guardian authorization and school acceptance

I request that Ypsilanti Community Schools personnel administer the medication listed on this form according to the directions of the prescribing physician/licensed health care provider and YCS procedures.
Medication must be supplied in the original pharmaceutical container labeled with the scholar's name, medication name, dosage, and administration instructions. Medication will remain at school unless other arrangements have been made with the school principal and/or school nurse.
I give permission for the prescribing provider, school nurse, and appropriate school staff to share information needed to safely meet my scholar's medication needs. I will provide the school with written notice of medication changes.

PARENT / GUARDIAN AUTHORIZATION - SELECT ONE

☐ School personnel will administer this medication.

☐ Scholar may self-administer under supervision of school personnel.

☐ Scholar may carry and self-administer this medication. (No controlled substances.)

FOR SELF-CARRIED / SELF-ADMINISTERED MEDICATION

☐ Medication may be lost, stolen, or misused.

☐ School may not keep a separate record of each self-administered dose.

☐ Self-carry/self-administration privileges may be revoked if concerns arise regarding safe or appropriate use.

Scholar has demonstrated safe self-administration of medication: ☐ Yes ☐ No

PARENT / GUARDIAN SIGNATURE

Parent / Guardian Name (print)

Best Phone Number

Parent / Guardian Signature (type name if electronic)

Date

Alternate Phone

Relationship to Scholar

SCHOOL ACCEPTANCE - SELF-CARRIED / SELF-ADMINISTERED MEDICATION ONLY

School Nurse / Designee Signature (type name if electronic)

Date

Building Principal Initials

IMPORTANT INFORMATION

- Medication should remain at school and should not be transported to and from school daily unless arrangements are approved by the principal and/or school nurse.
- Self-carried medication means the scholar possesses and administers medication without direct administration by school personnel. Controlled substances may not be self-carried.
- Medication stored by the school for administration or supervised self-administration requires both provider and parent/guardian authorization.
- Authorization must be renewed each school year.