

SOUTH LYON COMMUNITY SCHOOLS  
Permission Form for Prescribed and/or Non-Prescribed Medication

**Forms must be dated after July 1st of the school year in which the medication will be taken.**

Student _____	Date of Birth _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Grade _____
Home Phone Number _____	Parent/Guardian work phone number _____			
Date form received by school _____				

<b>To be completed by the Physician or Authorized Prescriber</b>	
Name of Medication: _____	Dosage: _____
Form of Medication: <input type="checkbox"/> tablet/capsule <input type="checkbox"/> liquid <input type="checkbox"/> inhaler <input type="checkbox"/> injection <input type="checkbox"/> nebulizer <input type="checkbox"/> other _____	
Reason for medication (optional): _____	
Time medication to be administered during school hours: _____	Dose: _____
Start medication: <input type="checkbox"/> Date form received <input type="checkbox"/> Other date (specify) _____	
Stop medication: <input type="checkbox"/> End of school year <input type="checkbox"/> Other Date (specify) _____	
<input type="checkbox"/> For episodic/emergency use only	Special Instructions: _____
Restrictions and/or possible side effects: _____	
Storage Requirements: <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other: _____	
This student is both capable and responsible for self-administering this medication: <input type="checkbox"/> No <input type="checkbox"/> Yes-supervised <input type="checkbox"/> Yes-Unsupervised	
Are there extenuating circumstances which make it necessary for the student to self-possess and self-administer this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
The student may carry this medication. If yes, parent must fill out Option 2. <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>PLEASE NOTE: NARCOTICS AND CONTROLLED SUBSTANCES SUCH AS RITALIN MUST BE DISPENSED THROUGH THE SCHOOL OFFICE.</b>	
Please indicate if you have provided additional information: <input type="checkbox"/> On the back of this form <input type="checkbox"/> As an attachment	
Physician/authorized prescriber signature: _____	Date: _____
Address: _____	Phone Number: _____

<b>To be completed by parent/guardian</b> Parent may pick more than one option	
<b>OPTION 1</b>	
I request that _____ receive the above medication in the school office according to South Lyon Community Schools Administration of Medication Policy.	
Parent/Guardian Signature _____	Relationship _____
Date _____	
<b>OPTION 2 (self-possess)</b>	
Our physician has indicated that there are extenuating circumstances which make it necessary for _____ to self-possess and/or transport this medication. However, it is necessary for _____ to have the medication administered by school personnel according to the South Lyon Community Schools Administration of Medication Policy.	
Parent/Guardian Signature _____	Relationship _____
Date _____	
<b>OPTION 3 (self-possess &amp; self-administer)</b>	
Our physician has indicated that there are extenuating circumstances which make it necessary for _____ to self-possess and self-administer this medication. Therefore, I request that the building administrator approve this request and allow my child to self-possess and self-administer the above medication at school according to the South Lyon Community Schools Administration of Medication Policy, and I agree that the Procedures for Self-Possession and Self-Administration found in that policy will be followed.	
Parent/Guardian Signature _____	Relationship _____
Student Signature _____	Date _____

Building Administrator Signature \_\_\_\_\_ Date \_\_\_\_\_

## PRACTICE/PROCEDURES FOR MEDICATION DISPENSED DURING SCHOOL

We recognize that some students are able to attend regular school because of the effective use of medication in the treatment of chronic disability or illness. We are also aware some prescriptions require that medication be given while the individual is in attendance at school. The following procedures will be followed in order to protect the student and the adult administering the medication:

### Prescription Medications

1. Written directions from the physician must detail the name(s) of the drug, dosage, and the time interval medication is to be taken. Directions must be renewed annually. Permission Forms for Prescribed and/or Non-Prescribed Medications may be obtained in the building office or on the [South Lyon Community Schools website](#).
2. Written permission from the parent/guardian requesting that the school district comply with the physician's order must be submitted with the physician's written directions. An appropriate form is available in the building office or on the [South Lyon Community Schools website](#).
3. ALL MEDICATION FORMS MUST BE SIGNED BY THE PHYSICIAN **AND** PARENT.
4. Medication must be brought to the school office by the parent/guardian unless other safe arrangements are made with the administration or other designated staff.
5. MEDICATION MUST BE BROUGHT TO THE SCHOOL IN THE ORIGINAL CONTAINER, as prepared by the pharmacy, physician or pharmaceutical company, with dosage, frequency of administration and expiration date clearly indicated on the container.
6. Medication must be supplied in exact dosage prescribed so that dividing pills is not the responsibility of school personnel.
7. No more than a forty-day supply of medication should be received from home. This will be stored in a locked cabinet and dispensed under the supervision of building personnel.
8. Prescription and medication supply renewal is the responsibility of the parent/guardian. School personnel will not administer expired medication.
9. Medication left over at the end of either the school year or the medication administration period, whichever occurs first, must be promptly picked up by the parent/guardian or an adult school employee will dispose of the medication and record this disposal on the medication log. No medication will be kept for more than one school year.
10. A written record of the administration of medication will be maintained in the building office.

### Over-the-counter Medications

1. If an elementary aged student requires administration of a non-prescription medication (i.e. aspirin, Tylenol, etc), a parent/guardian must submit written directions from a doctor (including name of medication, dosage, and time interval) AND permission to administer. Appropriate [forms](#) are available in the building office. Forms must be renewed annually. MEDICATION MUST BE BROUGHT TO THE SCHOOL BY PARENTS.
2. If a middle school aged student requires administration of a non-prescription medication (i.e. aspirin, Tylenol, etc), the parent/guardian must submit written authorization on the appropriate [form](#), giving student permission to self administer. Authorization must include the name of medication, dosage, and time interval.
3. If a high school aged student requires administration of a non-prescription medication (i.e. aspirin, Tylenol, etc), no written authorization is required.