

Medication Form 2014

WEST BLOOMFIELD SCHOOL DISTRICT

Permission Form for Prescribed or Over the Counter Medication
Including Self Administration and Self-Possession of Medications

It is the policy of the West Bloomfield School District, in compliance with Compiled Laws Section 380.1178 to have written authorization for a student to take prescribed or over the counter medication during the school day. This information will be handled in a confidential manner.

Name: _____ Birth Date: _____

Physician's Signature _____ Date _____

Parent Signature _____ Date _____

My child has Physician permission to take the following Over-the-Counter (OTC) Medications. Circle all that apply.

Acetaminophen

Antihistamine

Antacid

Antibiotic ointment

Benadryl

Calamine Lotion

Cough Suppressant

Decongestant

Ibuprofen

Imodium

Topical Analgesic

_____ This student does not take any prescribed medication and will not take any Over the Counter (OTC) medications

_____ This student takes medication as follows, including any OTC not listed above:

Name of medication: _____ **Dosage** _____

Specific time(s) taken _____ Reason for taking _____

Student is both capable and responsible for:

Self-administering this medication ___ No ___ Yes-Supervised ___ Yes-Unsupervised

Name of medication: _____ **Dosage** _____

Specific time(s) taken _____ Reason for taking _____

Student is both capable and responsible for:

Self-administering this medication ___ No ___ Yes-Supervised ___ Yes-Unsupervised

Name of medication: _____ **Dosage** _____

Specific time(s) taken _____ Reason for taking _____

Student is both capable and responsible for:

Self-administering this medication ___ No ___ Yes-Supervised ___ Yes-Unsupervised