Medication Form 2017

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