# SAGINAW TOWNSHIP COMMUNITY SCHOOLS
# ADMINISTRATION OF MEDICATION CONSENT FORM

Student's Name_____

Birthdate_____Grade_____Today's Date_____

## Medication Information

(To be completed by Health Care Provider)

Name of Medication_____

Purpose of Medication_____

Dosage_____Route & Frequency_____

Expiration Date_____Time to Administer Medication_____

Directions for Administration_____

Length of Time Medication will be prescribed_____

Side Effect of Medication/Comments_____

Restrictions

- ❑ Yes If yes, what and how long?_____
- ❑ No

For Inhaled/Injected Medication- ☐Asthma Management Plan/Allergy Action Plan Completed

- ❑ I have instructed student in the proper way to use his/her inhaler/Epi Pen. It is my professional opinion that he/she be allowed to carry and use the inhaler/Epi Pen by him/herself.
- ❑ It is my professional opinion that the student should not carry or administer inhaler/Epi Pen by him/herself.

Attending Physician_____Date_____

Signature

Printed Name & Address of Physician_____

I hereby request that my child be administered the prescribed medication at school by designated school personnel. I understand that the medication will be administered as per the directions of the above named physician. I will notify the school of changes or discontinuance of this medication(s) immediately.

Parent/Guardian_____Date_____

signature

Address_____Phone_____

M.C.L.A. S 380.1178 states the following " a school administrator, teacher or other school employee designed by the school administrator, who in good faith administers medication to a pupil in the presence of another adult pursuant to written permission of the pupil's parent or guardian and in compliance with the instructions of the physician is not liable in criminal action or for civil damage as a result of administration except for an act or omission amounting to gross negligence or willful and wanton misconduct." File in CA60