



FERNDALE PUBLIC SCHOOLS

Enrollment & Pupil Services Office • 248/586-8686

Authorization to Administer Medication

It is the policy of Ferndale Public Schools to have written authorization for a student taking prescribed medication during the school day. This information will be handled in a confidential manner.

Date Received at School _____ Child's School _____ Teacher _____ Grade _____ Room _____

Child's Name- Print _____ Child's Birthdate _____

Address _____ Phone (_____) _____

This section must be completed by the student's Physician or Authorized Prescriber

Name of Medication _____

Reason for Medication _____

Start Date _____ Date Form Received _____
 Throughout the School Year For Episodic/Emergency Events Only

End Date _____

Form of Medication/Treatment:

- Tablet/Capsule Nebulizer Other conditions that may require treatment or hospitalization
- Inhaler
- Injection

Instructions (Schedule and Dose to be given at school) _____

Restrictions and/or important side effects (Please describe) _____ None expected

This student is both capable and responsible for self-administering this medication:

- Yes, if supervised Yes, unsupervised (only inhalers may be carried by students) No

Please indicate if you have provided additional information:

- On the back of this form As an attachment Refrigerate None

Special Storage Requirements _____

Physician's Name (Please Print) _____ Office Phone (_____) _____

Address _____

Physician's Signature _____

Waiver of Release of Liability

I, _____, knowingly authorize the Ferndale Public Schools, its Board

Print Name of Parent or Guardian

Members, employees, agents, delegates, or those persons working within the district, to administer medication and medical treatment to _____ as required according to the good faith judgment

Child's Name

of those persons authorized to administer this medication and treatment. The undersigned further expressly and knowingly agrees to hold Ferndale Public Schools, its Board members, employees, agents, delegates or those persons employed as teachers or otherwise working within the district, harmless and otherwise not liable in criminal actions, or for civil or other damages as a result of the administration of such medication or medical treatment. I advise school personnel that the above named student is taking the medication named above during school hours, according to the physician's directions. I will notify the school of any changes in or discontinuation of this medication.

Parent/Guardian Name (Last, First) _____ Daytime Phone (_____) _____

Parent/Guardian Signature _____ Today's Date _____