FERNDALE
SCHOOLS

PARENT – Please print, fill out, and deliver to your school's office.

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(s)

_____
Reason for Medication

_____ _____
Start Date | Date Form Received

_____ o Throughout the School Year o 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)

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

This student is both capable and responsible for self-administering this medication:
o Yes, if supervised o Yes, unsupervised (only inhalers may be carried by students) o No

Please indicate if you have provided additional information:
o On the back of this form o As an attachment

_____ o Refrigerate o None
Special Storage Requirements

_____ (_____)_____
Physican's Name (Please Print) | Office Phone

_____
Address

_____
Physician's Signature

WAIVER OF RELEASE OF LIABILITY

I, _____, knowingly authorize the Ferndale Public Schools, its Board Members, employees, agents, delegates, or those persons working within the district, to administer medication and medical treatment to _____
Print Name of Parent or Guardian *Child's Name*
as required according to the good faith judgement of those persons authorized to administer this medication and treatment. The undersigned further expressly and knowingly agrees to hold Ferndale Public Schools, its Board memebers, 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 physicians 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