

**NICE COMMUNITY SCHOOLS  
PERMISSION FORM FOR PRESCRIPTION/NON-PRESCRIPTION MEDICATION (Y5-12)**

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_ Teacher/Homeroom \_\_\_\_\_  
Date Form Received by the School \_\_\_\_\_

**The Michigan State Law, Act 451 of 1976 states: 380.1178. Administration of medication to pupil; liability; Sec. 1178. School administrator, teacher, or other school employee designated 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 parents or guardian and in compliance with the instructions of a physician is not liable in a criminal action or for the civil damages as a result of the administration except for an act of omission amounting to gross negligence or willful and wanton misconduct.**

The Board policy of the NICE Community Schools provides that administration of medication (prescription/non-prescription) in school must be on the basis of written permission by the parent or guardian and must be done in compliance with a physician's instructions.

**MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION CONTAINER** clearly labeled with the name of the student; name and dosage of the medication, method of dispensation; time of day to be given, name of physician; date issued, pharmacy name, address, and phone number. **ALL MEDICATION FOR Y5- 12 MUST BE BROUGHT TO THE SCHOOL BY A PARENT OR DESIGNATED ADULT.** If these guidelines are not followed the medication will **NOT** be given.

**OVER THE COUNTER MEDICATIONS** will **NOT** be dispensed without **written permission** by the student's parent/guardian.

**TO BE COMPLETED BY PARENT/GUARDIAN**

I request that (name of child) \_\_\_\_\_ receive the medication listed below at school according to the standard school policy.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

**I understand that it is the responsibility of my child to report to the office for his/her medication(s). I also understand that it is my responsibility to notify the school of change or discontinuation of the medication(s).**

**On shortened school days, dispensing of medication will be the responsibility of the parent.**

By law, any unused, discarded or outdated medicine must be picked up by the parent/guardian within seven (7) days of notification by school authorities or the medication must be destroyed by school personnel.

**TO BE COMPLETED BY THE PHYSICIAN/AUTHORIZED PRESCRIBER FOR PRESCRIPTION MEDICATIONS**

Name of medication \_\_\_\_\_

Reason for medication (OPTIONAL) \_\_\_\_\_

Form of medication/treatment: \_\_\_\_ Tablet/capsule \_\_\_\_ Liquid \_\_\_\_ Inhaler \_\_\_\_ Injection \_\_\_\_ Other

Instructions (schedule and dose to be given at school) \_\_\_\_\_

**Start** Date form received \_\_\_\_\_ Other dates \_\_\_\_\_

**Stop** End of school year \_\_\_\_\_ Other date/duration \_\_\_\_\_

Instructions in case of missed dosage \_\_\_\_\_

Restrictions and/or important side effects \_\_\_\_ None anticipated \_\_\_\_ Yes, please describe \_\_\_\_\_

**Health Care Provider's Name** \_\_\_\_\_

**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Date** \_\_\_\_\_ **Signature** \_\_\_\_\_

Building Administrator's Signature \_\_\_\_\_ Date \_\_\_\_\_

Nurse's Signature \_\_\_\_\_ Date \_\_\_\_\_