THE GROSSE POINTE PUBLIC SCHOOL SYSTEM
MEDICATION PRESCRIBER/PARENT AUTHORIZATION FORM

Student Name:_____Birthdate:_____Teacher:_____Grade:_____School Year:_____

TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

	Medication Name	Dose	Time To Be Given	Form of Medication *	Storage (Refrigeration?)	Restrictions / Side Effects
1						
2						

*Form of Medication:

_____tablet/capsule _____chewable/liquid ____ inhaler/nebulizer ____topical skin application/ointment _____other _____

Reason for medication (optional): Medication # 1_____ Medication #2_____

Special Instructions:_____

Start date (if not beginning of the school year) _____Stop date (if not end of the school year:)_____

_____ _____ _____
Physician's Signature Date Physician's Printed Name

Physician's Phone #:_____ Fax #: _____ Address: _____

TO BE COMPLETED BY PARENT/GUARDIAN:
I request and give permission for (name of child) _____ of _____ School to receive the above medication(s) treatment at school according to school district policy and for the physician's/staff and school district staff to share information needed to assist my child with medication needs. (PLEASE NOTE: Michigan law and the Grosse Pointe Public School System Board of Education Policy and Regulation 5330 require that this medication be brought to school in its original container.)

_____ _____
Parent / Guardian Signature Date