

Bay City Public Schools
Self-Administered Medication Authorization Form (Med-3)

According to P.A. 10 of 2000, a student may possess and use at school a metered dose inhaler or a dry powder inhaler for the relief of asthma symptoms. Self-administration means that the student can administer the inhaler in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on her/his person to allow for immediate and self-determined administration. Spare inhaler medication, with prescription label, may be kept in the office in case the student runs out/forgets the medication. The building administrator may discontinue the student's self-administration privilege upon advanced notice to the parent/guardian.

Student Name _____ Birthdate _____ Teacher/Counselor _____ Grade _____ School Year _____

To be completed by physician/licensed prescriber:

	<u>Medication</u> (with prescription label)	<u>Dose</u>	<u>Time To be Given</u>	<u>Form/Route</u>	<u>Possible Side Effects</u>	<u>Adverse Reactions</u>
1						
2						

List symptoms/conditions under which medication ordered as needed (**p.r.n.**) is to be given: _____

Special Instructions: _____

If **p.r.n.**, MINIMUM amount of time between doses: _____

Start date: _____ Stop date: _____

The student is capable of: _____self-administering _____self-possessing the above medication(s).

Physician's Printed Name: _____ Physician's Phone #: _____ Physician's Fax #: _____

Physician's Signature: _____ Physician's Address _____ Date: _____

To be completed by parent/guardian:

I request and give permission for (name of child) _____ to ___self-administer and ___self-possess the above medication(s) at school according to standard school district policy and for the physician's staff and school personnel to share relevant information regarding my child's medication needs.

Parent/Guardian Signature _____

Date _____

Student Name: _____

To be completed by student and parent/guardian

I agree to:

1. Never share my medication with another person.
2. Carry the medication in its original properly labeled prescriptive/over-the-counter container.
3. Take medication only at the prescribed time/frequency and dose.

I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parents/guardian, and the privilege(s) of self-administration/self-possession denied.

Student Signature: _____ Date _____

ParentGuardian Signature: _____ Date _____

Note: Parent must also complete the Parental Request Form.