# Comstock Park Public Schools

## Medication Administration Authorization Self-Administration/Self-Possession Form

Michigan State Law requires that students self-administering medications must have written orders from the physician/licensed prescriber and written authorization from the parent/guardian. **"Self-administration"** means that the student can administer the medication 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 his/her person to allow for immediate administration.

- Medications must be prescribed in writing by a physician or other licensed prescriber and must be renewed at least annually.
- All medication must be brought to school in the original pharmacy or OTC container labeled with the name of the student, medication, dosage, route and time(s) to be given.
- Medications and related equipment/supplies, as ordered, must be provided to the school by parent/guardian as needed.
- Any misuse of medication by a student that violates school policies, including sharing medication for any reason, will result in revocation of self-possession privileges and may result in a referral to law enforcement officials.
- If your child is Medicaid eligible, school health services may be billed on behalf of the school. School district billing will not impact future benefits of your family's Medicaid plan.

**STUDENT'S NAME:** _____ **DATE OF BIRTH:**_____

**SCHOOL:**_____ **TEACHER:**_____ **GRADE:**_____

**TO BE COMPLETED BY THE PHYSICIAN:**

| Medication Name | Dosage | Route | Time and Frequency |
|---|---|---|---|
| | | | |

Form of medication: ❑Tablet/capsule ❑Liquid ❑Inhaler ❑Injection ❑ Nebulizer ❑ Other_____

Special instructions/storage requirements:_____

Signs/Symptoms for which medication is being prescribed:_____

Restrictions and/or side effects:_____

Order Start Date:_____ Order End Date:_____

**Student is capable of and authorized to:** ❑ self-administer the above medication ❑ self-possess the above medication

**NOTE:** To participate in Medicaid School Services Program, a valid prescription MUST be signed and dated by a physician or other licensed prescriber and include the prescriber's name, address, telephone number, and NPI number.

Provider Signature:_____ Printed Name:_____

Date:_____ Phone:_____ Fax:_____ NPI #:_____

Address:_____

**TO BE COMPLETED BY THE PARENT/GUARDIAN:**

I hereby authorize trained school staff to administer the identified medication, ordered by the licensed prescriber, to the child above. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA. I will not hold the Board of Education or its personnel responsible for complications related to the medication.

Student is capable of and authorized to: ❑ self-administer the above medication ❑ self-possess the above medication

Signature: _____ Date: _____

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

Signature: _____ Date: _____

District: P 616-254-5030 F 274-4988 Greenridge P 616-254-5700 F 276-3305 Stoney Creek P 616-254-5600 F 276-3305
Pine Island P 616-254-5500 F 276-3303 Mill Creek P-616-254-5100 F 276-3302 High School P 616 254-5200 F 276-3301