

Prescription Medication Administration Release Form All Saints Academy

Elementary Campus: 2233 Diamond Ave. NE ❖ Grand Rapids ❖ MI ❖ 49505 ❖ Phone: 616-364-9453
Middle School Campus: 1110 Four Mile Rd. NE ❖ Grand Rapids ❖ MI ❖ 49525 ❖ Phone: 616-363-7725

If your child must take prescription medication while at school,

1. Except for rescue inhalers, students are NOT ALLOWED to carry medications of any kind on their person or keep them in their locker. All meds must be dispensed from the school office.
2. Parents MUST supply the medication in the original package.
3. Medication must be brought to school by the parent/guardian.
4. Medication must have the prescription label attached with name and dosage.
5. Complete this form and return it to the school office with labeled medication.

Date: _____

Child's Name: _____ Birth Date: _____ Teacher: _____

Address: _____ Emergency Phone: H _____

Parent/Guardian : _____ W _____

I hereby request and authorize school personnel to administer my child's prescribed medication as directed by our doctor or non-prescription medications, including aspirin related products and cough drops.

Administration of medication to pupil; liability.

A 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 parent or guardian and in compliance with the instructions of a physician is not liable in a criminal action or for civil damages as a result of the administration except for an act or omission amounting to gross negligence or willful and wanton misconduct.

– Michigan Compiled Laws, 1982 (380.1178)

Signed: _____

(Parent or Guardian)

YOUR CHILD WILL BE UNABLE TO TAKE MEDICATION AT SCHOOL UNLESS THE SECTION BELOW IS COMPLETED AND SIGNED BY YOUR DOCTOR.

Doctor's Orders & Directions

You are hereby directed to give to _____ his/her medication _____
(Name of Child) (Name of Medication)
in the amount of _____ tablets/capsules or _____ teaspoons at _____ a.m./p.m. daily, or as follows:

Duration: _____

Possible side effects: _____

Physician's Signature _____ Telephone Number: _____

Printed or Typed Physician's Name: _____

Date: _____