AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

OSCODA AREA SCHOOLS

2016-2017

Section 380.1178, PA 51 of 2002

A school administrator, teacher, or other school employee designated by a school administrator, who in good faith administers mediation to a pupil in the presence of another adult, or in an emergency that threatens the life of health of the pupil, 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 civil damages as a result of the administration except for an act or omission amounting to gross negligence or willful and wanton misconduct.

PHYSICIAN'S ORDERS FOR MEDICATION DURING SCHOOL

Student Name _____ Grade _____ Medication _____ Dosage _____

Time to be given at school _____ Beginning _____ Discontinue _____

Purpose of Medication _____

Signature of Physician _____

CODES

(A) Absent (E) Early Dismissal (N) No Medication

(O) No Show (W) Dosage Withheld

(F) Field Trip ☐ No School

INTIAL	**SIGNATURE**	**INITIAL**	**SIGNATURE**
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Directions: Initial with time of administration; a complete signature and initials of each person administrating medications should be included above.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
SEPT																															
OCT																															
NOV																															
DEC																															

Unusual Occurrence Report

Initial	Date	Comment	Initial	Date	Comment
____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____

Count when receive medicine

Date	Count	Initials

Parent/Guardian Authorization

I hereby request that school personnel give my child _____, the medication ordered above by the physician and will not hold the Board of Education or its personnel responsible for complications related to the medication, pursuant to public Act 51 of 2002. I understand this is a voluntary service for which I assume the full responsibility. **A copy of the adverse reactions to this medication is attached to this form.**

Parent/Guardian Signature _____ Date _____

Print Child's Name _____ Child's Teachers _____

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

OSCODA AREA SCHOOLS

2016-2017

Section 380.1178, PA 51 of 2002

A school administrator, teacher, or other school employee designated by a school administrator, who in good faith administers mediation to a pupil in the presence of another adult, or in an emergency that threatens the life of health of the pupil, 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 civil damages as a result of the administration except for an act or omission amounting to gross negligence or willful and wanton misconduct.

PHYSICIAN'S ORDERS FOR MEDICATION DURING SCHOOL

Student Name _____ Grade _____ Medication _____ Dosage _____

Time to be given at school _____ Beginning _____ Discontinue _____

Purpose of Medication _____

Signature of Physician _____

CODES

(A) Absent (E) Early Dismissal (N) No Medication

(O) No Show (W) Dosage Withheld

(F) Field Trip ☐ No School

INTIAL	**SIGNATURE**	**INITIAL**	**SIGNATURE**
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Directions: Initial with time of administration; a complete signature and initials of each person administrating medications should be included above.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JAN																															
FEB																															
MAR																															
APR																															
MAY																															
JUNE																															

Unusual Occurrence Report

Initial	Date	Comment	Initial	Date	Comment
____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____

Count when receive medicine

Date	Count	Initials

Parent/Guardian Authorization

I hereby request that school personnel give my child _____, the medication ordered above by the physician and will not hold the Board of Education or its personnel responsible for complications related to the medication, pursuant to public Act 51 of 2002. I understand this is a voluntary service for which I assume the full responsibility. **A copy of the adverse reactions to this medication is attached to this form.**

Parent/Guardian Signature _____ Date _____

Print Child's Name _____ Child's Teachers _____