WYANDOTTE PUBLIC SCHOOLS

Medication/Medical Procedure Physician/Parent Authorization

Michigan law requires a physician's written order and parent/guardian authorization for administration of medication/medical procedures to be done in school

Name: Birthdate: School Year	r:
------------------------------	----

To be completed by physician/licensed prescriber:

Medication Name	Dose	Time Given	Route/Form	Reason Given
Special Treatments: (t-feedings, 02,	suction anth ata)			
Special Heatments. (t-feedings, 02,				

PRN meds – list minimal frequency between doses and conditions under which medication is to be given:

Special Instructions and/or important side effects:

Physician's Signature:	Physician's printed name:	Date:
Physician's phone and fax number:		
Physician NPI number		
Physician's address:		
To be completed by parent/guardian:		
I request and give permission for my child to receive the above medica	ations/treatment at school in accordance with district policy, and for ph	ysician's staff and

school district staff to share information as needed to assist my child with his/her medical needs. The medication and/or supplies will be provided by me to the school district in accordance with school district policy.

Parent/Guardian Signature:_____ Date:_____

Home Phone:______Cell Phone______Work Phone ______

1