Prescription Medication

Administration Release Form

All Saints Academy

Lower Campus: 2233 Diamond Ave. NE ● Grand Rapids ● MI ● 49505 ● Phone: 616-447-2997
Upper 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: ____________________