Medication Form 2019

WEST BLOOMFIELD SCHOOL DISTRICT
Permission Form for Prescribed or Over the Counter Medication
Including Self Administration and Self-Possession of Medications

It is the policy of the West Bloomfield School District, in compliance with Compiled Laws Section 380.1178 to have written authorization for a student to take prescribed or over the counter medication during the school day. This information will be handled in a confidential manner.

Name: ____ Birth Date: _______________

Physician's Signature _________________________________ Date_____________

Parent Signature _____________________________________ Date_____________

My child has Physician permission to take the following Over-the-Counter (OTC) Medications.
Circle all that apply.

Acetaminophen	Antihistamine	Antacid	Imodium
Antibiotic ointment	Benadryl	Calamine Lotion	Topical Analgesic
Cough Suppressant	Decongestant	Ibuprofen	

_______This student does not take any prescribed medication and will not take any Over the Counter (OTC) medications

_______This student takes medication as follows, including any OTC not listed above:

Name of medication: ________________________________ Dosage______________

Specific time(s) taken ________________________ Reason for taking________________

Student is both capable and responsible for:
Self-administering this medication ____No ____Yes-Supervised ____Yes-Unsupervised

Name of medication: ________________________________ Dosage______________

Specific time(s) taken ________________________ Reason for taking________________

Student is both capable and responsible for:
Self-administering this medication ____No ____Yes-Supervised ____Yes-Unsupervised

Name of medication: ________________________________Dosage______________

Specific time(s) taken ________________________Reason for taking________________
Student is both capable and responsible for:
Self-administering this medication ____No ____Yes-Supervised ____Yes-Unsupervised