Bedford Public Schools Health Services

Dear Parent/Guardian,

Please return the Medication Authorization form **on the back of this letter** to the school with your child's medication. We also ask that you follow these instructions when sending medication of any kind to the school for administration.

1. Any medication should be taken at home if at all possible.

2. Medications to be given at school **must** be brought to and from school by a parent/guardian.

3. Medications must be in their original container, labeled with:
    a. Name of student
    b. Name of medication
    c. Time of administration
    d. Dosage
    e. Route of administration
    f. Expiration date

*Most pharmacies will be glad to provide you with duplicate containers if you request them.

4. Both prescription and over-the-counter medications must be accompanied by written, signed instructions from a **physician** and signed authorization by a **parent/guardian**.

5. It is the responsibility of the student to report to the health room at the time the medicine is to be taken.

6. Refill of the medication is the responsibility of the parent/guardian.

7. Expired medications will not be administered.

8. Unused medication will be discarded unless picked up by parent/guardian on or before the last day of school.

Additional medication authorization forms can be obtained from the Bedford Public Schools website: www.mybedford.us. Please contact the district nurses at (734) 850-6034 if you have any questions concerning the medication policy and procedures.

Sincerely,
Karen Weis RN, BSN
Mindy Klawonn RN
District Nurses

Bedford Public Schools Health Services

Authorization for the Administration of Medication at School

*** The length of time which medication shall be administered shall be one school year, from September to June. All medication authorizations must be renewed at the beginning of each school year. Authorization forms must be completed for both prescription and over-the-counter medications.**

Student: _____ Date of Birth: _____ Grade: _____ Teacher: _____

Physician's Name: _____ Physician's Phone: _____

Physician's Address: _____ City/State/Zip: _____

TO BE COMPLETED BY THE PHYSICIAN:

Name of medication: _____

Dosage: _____ Time of Administration: _____
Form of Medication/Treatment: __ Tablet/Capsule __ Inhaler __ Injection __ Nebulizer __ Other

Purpose of Medication: _____

Start date if not beginning of the school year: _____
Stop date if before the end of the school year: _____

Possible Side Effects: _____

Students may **ONLY** be allowed to carry inhalers, epi-pens or insulin with **special authorized permission.**

Student may carry INHALER: ____No ____Yes
Student may carry EPI-PEN: ____No ____Yes
Students that carry inhalers and Epi-Pens may not be supervised during administration.

Student is both capable and responsible for self-administering insulin. (See Diabetes Care Plan)
____No ____Yes-Supervised ____Yes-Unsupervised

Student is both capable and responsible for carrying insulin. ____No ____Yes

The building administrator may discontinue the student's carrying and self-administration privileges upon advanced notice to the parent/guardian.

Physician Signature: _____ Date: _____

I hereby request that my child be administered the prescribed medication at school according to district policy. I understand that the medication will be administered as directed by the above named physician. I will notify the school of changes or discontinuation of this medication. I further agree that you may contact the physician who prescribed the medication and I hereby authorize the physician to release to the school nurse any and all information concerning my child's condition and/or treatment.

Signature:_____ Relationship:_____ Date: _____