TBA ISD LEADING LIFETIME LEARNING

Traverse Bay Area Intermediate School District
1101 Red Drive
Traverse City MI 49684
231-933-5758•FAX: 231-933-5840

Authorization for Medication Administration

Student Name:_____

UIC #:_____

DOB:_____ Phone Number:_____

Address:_____

City, State, ZIP:_____

Reviewed:_____RN initials:_____

Prescribing Physician's Name:_____

Address:_____

City, State, Zip:_____

Phone: _____

School:_____ Program:_____ Teacher:_____

I hereby authorize the above named source to release or disclose to the Traverse Bay Area Intermediate School District the following information for the student listed above:

1) All medical records or other information regarding the treatment and/or outpatient care for the following conditions, including psychological, medical, and physical.
2) Information about how the disability affects ability to complete tasks and activities of daily living in and around the school setting, including but not limited to classroom, gymnasium, and playground.

The undersigned parents/guardian authorize the Traverse Bay Area Intermediate School District through its administrators, teachers, or transportation staff to administer medication or to supervise the taking of medication by my child.

It is understood that the undersigned parents/guardian has total responsibility for obtaining written physician authorization in the event the prescription shall be discontinued or modified.

The medication must be brought to school in a container appropriately labeled by the physician or pharmacy. Daily carrying of medication is to be avoided. Refill of the prescription shall be the responsibility of the parents or guardian.

I authorize the use of telefax, photocopy, and e-mail of this form for the release or disclosure of the information described on this form. I understand that this authorization, except for action already taken, may be voided by me at any time.

☐ I request that my child be allowed to self-administer the below medication according to school policy. I feel that he/she is both capable and responsible to hand carry and self-administer this medication. RN Initials:_____

_____ _____

Parent/Guardian Signature/Date **Verbal Parent/Guardian Authorization/Date**

(This form is valid from 9/1/2018 - 8/31/2019 only)

(This portion needs to be completed by a physician or in collaboration with school medical personnel)

Physician's Order:
(PLEASE SPECIFY INFORMATION FOR A 24 HOUR PERIOD, INCLUDING OVER-THE-COUNTER MEDICATIONS)

Diagnosis/Purpose of Medication:_____

Name of Medication:_____

Dosage:_____ Frequency:_____ Route:_____

Times:_____/_____/_____/_____/_____

(The school will be responsible for administration of doses during school and transportation hours only.)

Anticipated Duration (If for entire school year, so state.):_____

The prescription is (check one):

☐ Initiation of Therapy ☐ Adjustment of Dosage ☐ Maintenance Dosage ☐ Discontinuation of Therapy

Comments regarding this prescription [include adverse reaction, precautions, instructions (i.e., refrigeration), etc.]:_____

Physician's Signature:_____ Date:_____

Print Name: _____ **Physician's NPI Number**_____