PARENTS: **Please return this form to the Meads Mill office when your student needs to take prescription or over the counter medication.**

NORTHVILLE PUBLIC SCHOOLS
Meads Mill Middle School
16700 Franklin Road
Northville, MI 48168

PERMISSION TO ADMINISTER PRESCRIBED AND OR OVER THE COUNTER MEDICATION.

Student Name _____ Grade _____

Purpose of Medication _____
_____

Prescription(s):

1. Name of Medication_____
   Dosage _____ Frequency _____
   Time of Administration _____

2. Name of Medication_____
   Dosage _____ Frequency _____
   Time of Administration _____

3. Name of Medication_____
   Dosage _____ Frequency _____
   Time of Administration _____

Comments regarding prescription (diagnosis or reason for taking medications, adverse reactions, precautions, etc.): _____
_____
_____

Physician's Name (Printed) _____ Telephone _____

Physician's Address _____

Physician's Signature _____ Date _____

I hereby authorize appropriate school personnel to administer prescribed medication to _____. I understand that the medication will be administered as per the directions of above named physician. I will notify the school of changes or discontinuation of this medication(s).

_____ _____

Parent/Legal Guardian Address Phone

medform.09

See Reverse Side for Asthma Medications

Asthma Management Plan

Northville Public Schools

School Year _____

Please provide your child's photo here

Student's Name: _____ Birthdate: _____

School: Meads Mill Middle School Grade: _____

Physician/Licensed Prescriber:

Diagnosis: _____

Medication Name: Metered Dose Inhaler (MDI) Albuterol or _____

Dose/Frequency: 2 puffs every 4 hours as needed for symptoms or _____

Child should use a spacer device with inhaler Yes No

Child is able to self-administer medication and should be allowed to carry inhaler Yes No
(If child will be carrying inhaler, back up inhaler should be kept in the school office/clinic)

✓ Inhaler will be kept in: school office/clinic _____ backpack _____ desk _____ other _____

Directions for use:

- Shake well
- Insert inhaler mouthpiece into spacer (if provided)
- Position as instructed by health care provider
- Press down on the inhaler to release the medication and have child breathe in slowly and deeply. This is a puff.
- Have child hold their breath for 10 seconds to allow medication to stay in the lungs
- Wait for 1 minute, administer 2nd puff.
- Child should respond to treatment within 5-10 minutes
- If **no** change or breathing becomes worse, contact parent immediately
- If parent not available, or child's condition worsens, call 911

_____ _____ _____
Physician's Signature Date Phone Number

_____ _____
Physician's Name (Printed) FAX Number

Parent/Guardian:

I request and give permission for my child _____ to receive this medication(s)/treatment at school according to standard school district policy and for the physician or physician's staff and school district staff to share information needed to assist my child with medication needs. The school requires parent/guardian to bring medication in its original container. All medication must be labeled with the student's name.

_____ _____
Parent/Guardian Signature Date

_____ _____
Phone Number Emergency Phone Number

To be completed by student:

I agree to: Never share my medication with another person. Take medication only as prescribed by my doctor. Carry the medication in its original properly labeled prescriptive or over-the-counter container.
I am knowledgeable regarding the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and the privilege(s) of self-administration/self-possession denied.

_____ _____
Student's Signature Date