Lenawee Intermediate School District
Your Partner in Education for a Changing Tomorrow

Clinton Community Schools Medical Authorization Form

Name of Student: _____Date of Birth_____

Known Medication Allergies:_____

Name of Medication	1)	2)	3)	Tylenol/Motrin (Circle one if necessary)
Amount of medication				
Time of Administration				
Route of Administration				
Possible Side Effects				
Special Concerns or Comments				
Student Self Administer	YES NO	YES NO	YES NO	YES NO

Legal Prescriber's Printed Name_____

Prescriber's Signature (must be signed)_____Date_____

Address_____Telephone_____Fax_____

1) **No medication will be given without an order signed by the legal prescriber.**
2) **All prescription bottles must be labeled by the pharmacy with a current date, the name of the student, name of medication, strength of medication and time to be given.**
3) **All non-prescription medication must come to school in its original packaging.**
4) **Any change in dosage or addition of new medication must be accompanied by written legal prescriber's statement.**

I hereby request that my student be administered his/her medication by the school personnel authorized by the principal/supervisor. I understand that the medication will be administered as per the instructions of my above named physician. I will notify the school of changes or discontinuation of this medication(s).

Parent/Guardian Signature _____ Date_____

Clinton Elementary Nurse – Kristi Cymes Phone 517-456-6504 ext. 214 Fax 517-456-8201