



Lake Shore Public Schools

STUDENT MEDICATION PERMISSION FORM

School _____ School Year _____ Grade _____

Student	
Student's Last Name	Student's First Name
Date School Personnel may begin administering medicine:	
Time of day medicine is to be administered: AM PM	
Date school personnel stop administering medicine:	
Parent/Guardian	
Complete in writing in presence of school personnel Directions for administering medicine must be the same on medicine container as written here by parent/guardian	
NAME OF MEDICINE	DOSAGE
Doctor	
Doctor prescribing medication (print)	Doctor's signature
Address	City, State, Zip
Telephone	
Parent Consent	
I understand this medicine will be locked in the school principal's office area	
Parent/Guardian Name (print)	Parent/Guardian Signature
	Date
This form must be completely filled out to be valid.	
A new form must be filled out when a new medicine is prescribed.	
<p>MCL 389.1178 Administration of medication to pupil; liability. Sec. 1173 A school administrator, teacher, or other employee designated by the school administrator, who in good faith administers medication to a pupil in the presence of another adult or in an emergency that threatens the life or health of the pupil, pursuant to written permission of the pupil's parents or guardian, and in compliance with the instructions of a physician is not liable in a criminal action or for civil damages as a result of the administration except for an act or omission amounting to gross negligence or willful and wanton misconduct.</p>	