ORCHARD VIEW EARLY ELEMENTARY SCHOOL

2820 MACARTHUR AVENUE
MUSKEGON, MICHIGAN 49442-1498
231-760-1850

MEDICATION DISBURSEMENT FORM

Dear Parents:

When sending in your child's prescribed medication for authorized school personnel to be dispensed at school, you must follow the instructions listed below. These instructions are for prescription medication, inhalers, bees' sting kits, diabetic medication etc.

All **Prescribed medication** must be in the pharmacist's labeled container. Label must include:

1. The student's name
2. Physicians' Name
3. Name of Medication
4. The doses/amount and the correct times for dispensing
5. Date (the container must have the most recent date) Most pharmacies will be glad to provide you with a duplicate container for school use.

Medical forms must be filled out by a parent or guardian for both prescription and over the counter medication

Medication should be brought to school by a parent/guardian.

All medication in the form of pills must be counted and the amount written on the bottle. We will also count the medication when we receive it at school.

All prescription inhalers must be registered at the office, however, your student may carry the prescribed inhaler with them with a written consent from the physician.

All medication must be kept in the school office. Please complete the form on the reverse side and return to the office along with the medication.

Office staff will administer the above medication to the student.

I Acknowledge and will comply with the Board policy. The medications listed above will be supplied to Orchard View Early Elementary in the original container. I agree to notify the school in writing if the medication, dose, or schedule is changed or eliminated. I understand that medication must be sent by an adult. I also understand that it is the responsibility of my child to report to the office at the appropriate time for administering medication. I hereby release Orchard View Schools and school personnel from any liability that may result therein. I hereby give Orchard View Early Elementary School permission to administer to my child,

_____, the medication(s) listed below:
(Child's name)

_____ _____
Parent/Guardian signature Date

Please fill out other side of this form

Student's Name: _____Date of Birth _____

Grade:_____ Home/cell Phone Number_____

Parent or Guardian's name: _____

Child's teacher: _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER				
Name of Medication				
Reason for medication (optional):				
Form of medication/treatment:	Tablet/Capsule	Inhaler	EpiPen/Injection	Nebulizer
Instructions (Schedule and dose to be given at school):				
Start Date:	Date Form Received:		Other date/duration:	
Stop Date:	End of School Year:		Other date/duration:	
For Episodic/emergency events only:				
Restrictions and/or important side effects	No-None anticipated		**Yes-** please describe	
Special storage requirements	None		Refrigerate	Other
This student is both capable and responsible for self-administering this medication	No			
This student may carry this medication	No			
Please write all additional information on the back of this form or staple to as an attachment				

Parent's Signature _____

Physician's name: _____

Address: _____

Telephone Number: _____ Date: _____

Please fill out other side of this form