AUTHORIZATION FOR PRESCRIBED/NONPRESCRIBED MEDICATION OR TREATMENT

To the Parent:

In accordance with Policy 5330, before any prescribed or nonprescribed medication or treatment may be administered to any student, a written statement from the student's physician, or other health care provider, accompanied by a written authorization from the students' parent/guardian must be on file.

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED AND/OR NONPRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ _____

Name of Student Address

_____ _____

Program (CTE)/Classroom (Special Ed) Grade

A. I am requesting permission for my child named above to: (Check all that apply)

- _____ use or receive prescribed medication(s)
- _____ use or receive nonprescribed (i.e., over-the-counter), FDA approved medication(s)
- _____ receive prescribed treatment
- _____ self-administer prescribed medication(s) in my presence or that of an authorized staff member in accordance with the Doctor's prescription.

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication(s) or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____

Signature of Parent Date

_____ _____

Home Phone Cell Phone

PHYSICIAN STATEMENT

To the Physician:

The School District requires that all of the following information be provided before it will administer prescribed and nonprescribed (i.e., over-the-counter), FDA approved medication or treatment to the student named on the reverse side.

I have prescribed/recommended for use the following medication_____

_____

_____

Beginning Date _____ Ending Date_____

Dosage, instructions, or precautions (including possible side effects): _____

_____

_____

_____

I have prescribed the following treatment _____

_____

_____

_____

_____

_____

Beginning Date _____ Ending Date_____

Physician's Signature _____ Phone____ _____

Printed/Typed Name _____ Date _____

LCISD
Lapeer County Intermediate School District

1996 West Oregon Street
Lapeer, Michigan 48446

Phone (810) 664-5917 FAX (810) 664-1011
Michigan Relay Voice/TTY 800-649-3777

Consent for Disclosure of Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the student's name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

I authorize Lapeer County Intermediate School District to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.

Student's Name: _____ Date of Birth: __/__/__

Signature of Parent/Guardian
or Eligible Student: _____ Date:__/__/__

Printed Parent/Guardian Name: _____

Rev.8/2/18

LCISD Lapeer County Intermediate School District

Lapeer County Education and Technology Center

690 North Lake Pleasant Road
Attica, MI 48412-9303

Phone (810) 664-1124 FAX (810) 724-7600
Michigan Relay Voice/TTY 800-649-3777

MEDICAL HISTORY

2020-2021

NAME _____ DATE _____

ADDRESS _____ PHONE _____

City _____ Zip _____

Medication taken at home: _____

Date of last Physical Examination _____ Dental Examination _____

***Please indicate which of the following medical conditions your student has or has had by placing a check mark next to the condition and please explain:

LIST ALL Allergies: (creams, insects, food) _____

Other	___	Diabetes	___
		Behavior problems(explain)	___
No Known Allergies	___	Medicine	___
		Seizures(explain)	___
Special Diet	___	Dental (problems)	___
Feeding problems	___	Measles	___
Bladder	___	Mumps	___
Kidney	___	Rubella	___
Heart	___	Chicken Pox (date)	___
Bones (fractures)	___	Pneumonia	___
Ears	___	Injuries(explain)	___
Mouth	___	Operations(explain)	___
Skin(rash, irritation)	___		
Breathing(asthma,shortness)	___		

Special equipment and instructions for use:

Corrective Lens _____
Dental Prosthesis _____
Hearing Aid _____
Brace (type) _____
Instruction for use _____
Wheelchair _____
Crutches _____
Walker _____
Other _____

Physical limitations (feeding or other assistance)
*Please Specify _____