MICHIGAN: ACT NO. 431 of the Public Acts of 1978 (Section 380.1178 of the Compiles Laws of 1970)
Sec. 1178

A school administrator, teacher, or other school 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 parent or guardian, and in compliance with the instructions of a physician, physician's assistant, or certified nurse practitioner is not liable in a criminal action or for civil damages as a result of an act or omission in the administration of the medication, except for an act or omission amounting to gross negligence or willful and wanton misconduct.

L'ANSE CREUSE PUBLIC SCHOOLS
STUDENT MEDICATION
PARENTAL PERMISSION FORM

Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent requests for the administration of necessary prescribed medication to students. All medications must be in the original container, clearly labeled, indicating the following information: **Student's name, prescription number, medication name, dosage, date issued, doctor's name, pharmacy name, address and phone number.**

1. Name of Student _____
   (First) (Middle) (Last)

2. School _____Grade_____ Room _____

3. Name of Medicine _____ Prescription No. _____# Tablets _____
   30 day renewal of medication: same medication/same dosage:
   Prescription No:_____ Date:_____ Total Tablets _____
   Prescription No:_____ Date:_____ Total Tablets _____

4. Date school personnel may begin administering medicine: _____
   (Month - Day - Year)

5. Times of day medicine is to be administered: _____A.M. _____P.M.

6. This medicine is prescribed by Doctor _____
   Doctor's Address _____
   City and State _____
   Telephone Number _____

7. Directions and Procedures for administering medicine: **Must be the same as on the medicine container**.

_____

_____

_____

_____

(over)

8. I understand this medicine will be located in the school office area. I understand that it is the responsibility of my child to report to the office for his/her medication. I further understand that it is my responsibility to notify the school of change or discontinuation of the medication.

Parent/Legal Guardian must sign in presence of school personnel.

Signature of Parent/Legal Guardian _____ Date: _____

Address: _____

Telephone (home) _____ (work) _____

A NEW FORM MUST BE **COMPLETED** WHEN THERE IS A **CHANGE IN MEDICATION, DOSAGE OR TIME MEDICATION** IS TO BE ADMINISTERED.

Student's Name: _____

MEDICATION GIVEN

	Date	a.m.	p.m.	Tablets Remaining	Initials	Initials		Date	a.m.	p.m.	Tablets Remaining	Initials	Initials
1.							26.						
2.							27.						
3.							28.						
4.							29.						
5.							30.						
6.							31.						
7.							32.						
8.							33.						
9.							34.						
10.							35.						
11.							36.						
12.							37.						
13.							38.						
14.							39.						
15.							40.						
16.							41.						
17.							42.						
18.							43.						
19.							44.						
20.							45.						
21.							46.						
22.							47.						
23.							48.						
24.							49.						
25.							50.						