



Waterford School District – Plan of Care (POC) - Administering Medicines to Students

Bus Route #: _____

Student Name: _____ School: _____ Grade: _____

Dear Parents and Physician:

It is the policy of the Waterford School District, in compliance with Michigan Compiled Laws Section 380.1178, to have written authorization for a student to take prescribed medication during the school day. This information will be handled in a confidential manner. **Authorization is valid for one school year only.**

Student Date of Birth: _____

Check one (1):

- Authorization is hereby granted for school personnel to administer medication to the above named student, in accordance with the following physician’s directive
- I request that the above named student be allowed to carry/self-administer medication at the school according to school policy in pursuant to the physician’s approval.

1. Name of Medication: _____ Dosage: _____

Reason for medication: _____

To be given at: _____ (time/hour)

Date Range: _____ to _____

Comments regarding medication (adverse reactions, precautions, special instructions, etc.)

This student is both capable and responsible for carrying this medication Yes No

This student may carry this medication Yes No

2. Name of Medication: _____ Dosage: _____

Reason for medication: _____

To be given at: _____ (time/hour)

Date Range: _____ to _____

Comments regarding medication (adverse reactions, precautions, special instructions, etc.)

This student is both capable and responsible for carrying this medication Yes No

This student may carry this medication Yes No

In case of emergency, contact: _____ Phone _____

_____	_____	_____	_____
PARENT SIGNATURE	DATE	PHYSICIAN SIGNATURE	DATE
		Physician Name _____	
		Physician Address _____	
		Physician Phone _____	