MASON

Inspire ~ Empower ~ Succeed

Steele Elementary School
531 Steele Street (517) 676-6510
Mason, Michigan 48854 Fax (517) 676-0295

August 2017

Dear Parent,

The Mason Board of Education's policy regarding the administration of medications, including all over the counter medication is written below. All school personnel will be required to strictly follow these guidelines. I am asking that all parents also become familiar with this policy which follows Michigan law.

No medication of any kind, including non-prescription drugs, may be administered without **written permission from both the child's doctor and the parent**. A copy of the **Medication Administration Form** is attached below. Additional forms are available in the school office. Medications must be in the original container with the dosage and list of potential reactions and treatments attached. **If the child has a bee sting, nut or other serious allergy, an explanation of symptoms, and treatment required must be provided.**

All medication administered at school will be kept in a locked cabinet and will be given by a school employee and overseen by a witness. If your child is taking a three-times-a-day antibiotic, we encourage you to give a dose in the morning, a dose at home or daycare after school, and one in the evening.

For the safety of our children, please do not send medication to school with your child. All medication must be transported by a parent/guardian and administered by office personnel.

If you have any questions or concerns about this policy, please call the school office.

Mr. Kevin Dufresne
Principal

MEDICATION INFORMATION

MASON PUBLIC SCHOOLS

This form must be filled out and sent to school with ANY medication (prescription or over the counter) you wish to be administered by school personnel. A doctor's written instructions must accompany this form. Additional forms are available in the office. All prescription medication must be in the original pharmacy container.

DATE: _____ TEACHER'S NAME: _____

STUDENT NAME: _____ DATE OF BIRTH: _____

PHYSICIAN'S NAME: _____

PHARMACY PROVIDER: _____ RX # _____

NAME OF MEDICATION: _____

I HEREBY REQUEST AND AUTHORIZE SCHOOL PERSONNEL FROM THE SCHOOL LISTED BELOW TO ADMINISTER HIS/HER PRESCRIBED MEDICATION AS DIRECTED BY OUR DOCTOR.

☐ Alaiedon Elementary ☐ North Aurelius Elementary ☐ Steele Elementary

PARENT/GUARDIAN SIGNATURE: _____

DAYTIME PARENT/GUARDIAN PHONE NUMBER: _____

DOCTOR'S ORDERS

You are hereby directed to give to: _____
(Name of child)

his/her medication _____ *in the amount of* _____

before lunch *or* ***after lunch*** *(circle one) daily, or as follows:* _____
(Special Instructions)

_____ *for* _____
(Duration)

Possible side effects: _____

Doctor's signature: _____ *Telephone #:* _____