# EXHIBIT Appendix B

JGCD

**STUDENTS** **OCTOBER 18, 2024** ~~**APRIL 2018**~~
**MEDICATIONS**

The following Medication Authorization form is to be completed by physician and parent/guardian~~;~~ and maintained in the school office ~~with the Individual Student Medication Administration Log for each medication administered~~. The Medication Authorization form should be filed in the student's personal cumulative file at the end of the year and maintained for at least three years.

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## SAMPLE

## Medication Authorization

Student=s Name _____ Date _____

Date of Birth _____ School _____

Teacher/Counselor _____ Grade _____

**Both prescription and nonprescription medications require a completed Medication Authorization form signed by a physician and parent/guardian. If medication is related to a life-threatening health condition, Livonia Public Schools staff will develop an Individualized Health Care Plan in conjunction with the student=s physician.**

*TO BE COMPLETED BY THE PHYSICIAN*

Name of Medication _____ G Prescription G Non-Prescription

Reason for Medication _____

Form of Treatment G Tablet/Capsule G Inhaler G Liquid G Injection G Nebulizer

Instructions _____

Dosage _____

Time of Day G Daily G As Needed G Emergency Only G Other -

If dosage is Aas needed@ or Aemergency only@ specify symptoms and limits:

Relevant Side Effects _____

Storage Requirements G None G Refrigerate G Other -

Student is capable and responsible for self-possession and self-administering: G Inhaler G Emergency Meds

Please indicate if you have provided additional information: G On the back of this form G As an attachment

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Physician=s Name _____ Phone _____

Address _____ Fax _____

_____

Physician=s Signature _____ Date

*TO BE COMPLETED BY THE PARENT/GUARDIAN*

I request that _____
Student=s Name

G receive the above medication at school according to district policy.

G be allowed to self-administer the above medication (inhaler or emergency medication) at school according to district policy.

G I authorize school personnel to contact the above physician with questions or concerns relative to this authorization and medication.

_____ _____
Parent/Guardian's Signature Date

NOTES:

1. Medication includes prescription, non-prescription and herbal medications, and includes those taken by mouth, by inhaler, those that are injectable, and those applied as drops to eyes, nose, or medications applied to the skin.
2. Medications must be in an appropriately labeled container.
3. This authorization is valid for the current school year only.
4. This authorization must be maintained with the Individual Student Medication Log.
5. It will be the student=s responsibility to make contact with school personnel for the administration of medication, unless other arrangements have been made by the administrator.