ADRIAN PUBLIC SCHOOLS

Tradition of Opportunities

Future of Possibilities

Medication Authorization Form

Name of Student____ Date of Birth____________

Name of Drug	1)	2)	3)	Tylenol/Motrin (Circle one if necessary)
Amount of Medication				
Time of Administration				
Route of Administration				
Possible Side Effects				
Specials Concerns or Comments				

Physician's Signature___________________________________ Date____________________

Address____ Phone__________________

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1) **No medication will be given without an order signed by the physician.**
2) **All prescription bottles must be labeled by the pharmacy with a current date, the name of the student, name of medication, strength of medication and time to be given.**
3) **All non-prescription medication must come to school in its original packaging.**
4) **Any change in dosage or addition of new medication must be accompanied by written physician statement.**

I hereby request that my student be administered his/her medication by the school personnel authorized by the principal/supervisor according to Policy JHCD and JHCD-R . I understand that the medication will be administered as per the instructions of my above named physician. I will notify the school of changed or discontinuation of this medication(s).

Parent/Guardian Signature__________________________________ Date_________________

I request (name of student) _____________________________________ be allowed to self-administer and carry the above medication at school according to school policy.

Parent/Guardian Signature _________________________________ Date _________________