5425 Scio Church Rd.
Ann Arbor, MI 48103
734.665.5662
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Prescription Medication Form

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Student's name: ______________________________ Birth date (mm/dd/yy): _______________

Diagnosis: ____

Name of medication: ____

Direction for administration of medication:

____

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Additional comments:

____

____

Duration of treatment (limited to present school year):

____

_______________________________________ _______________________________________

Physician Name Physician Signature

____

Physician Registration No.

In the absence of a physician's signature on this form, please attach a physician's note.

_______________________________________ ______________________

Parent/guardian signature Date (mm/dd/yy)