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				
Student capable of self-administering medication	Yes No (Circle one)	Yes No (Circle one)	Yes No (Circle one)	Yes No (Circle one)
Student may carry medication on person	Yes No (Circle one)	Yes No (Circle one)	Yes No (Circle one)	Yes No (Circle one)

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 _____

Adrian High School: 517-263-2181 Fax: 517-266-4524

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