The Ann Arbor Public Schools require a physician’s written order and the parent’s or guardian’s written authorization for administration of all medications, including over-the-counter medications.

PHYSICIAN’S ORDER FOR MEDICATION ADMINISTRATION

Name ________________________________________________ Date ____________
Address _______________________________________________ Date of Birth ____________
Diagnosis _____________________________________________
Name of medication(s) ______________________________________________________
Time(s) of administration and dosage ________________
Relevant side effects, if any ___________________________________________________
Other suggestions ___________________________________________________________

The length of time that the medication shall be administered shall be one school year, from September to August. All medication authorizations must be renewed at the beginning of each school year.

Physician Signature ___________________________________
Address _______________________________________

I hereby request that my child be administered the above medication(s) at school by the school personnel. I understand that the medication(s) will be administered as directed by the above named physician and that each medication must come in its original container. I will notify the school in writing if an authorized medication is to be discontinued. If the administration of an authorized medication needs to be otherwise changed, I with resubmit an Authorization for the Administration of Medication form.

Parent/Guardian Signature ___________________________________ Date ____________

8/2011dg