

Ann Arbor Public Schools
Pioneer High School
Authorization For The Administration Of
PRESCRIPTION MEDICATIONS
Pioneer Fax: 734-994-2198

A physician's written order and the parent's/guardian's written authorization is required for administration of prescription medicines by school personnel.

Student's Name: _____ Date: _____

Grade: _____ Date of Birth: _____

Diagnosis: _____ Medication Allergies: _____

Drug:	1.	2.	3.	4.
Amount of Drug:				
Time(s) of Administration:				
Condition of which drug is administered:				
Possible side effects:				
Instructions or Comments:				

- All medication authorizations must be renewed at the beginning of each school year.
- All medication authorizations expire at the end of the school year.
- Medications **must** be in the original pharmacy container.
- Any change in dosage or addition of new medication requires a new physician's authorization.



I hereby request that my child be administered the prescribed medication(s) listed above, at school, by school personnel. I understand that the medication(s) will be administered as stipulated above, as authorized by the undersigned physician. I will notify the school in writing if this medication is to be discontinued. This notification will include authorization of the physician. If the administration of medication(s) needs to be otherwise changed, I will resubmit an Authorization for the Administration form.

Parent's/Guardian's Signature

Date

Phone Number

Physician's Signature **required**

Date

Phone Number