SOUTHFIELD PUBLIC SCHOOLS
AUTHORIZATION FOR MEDICATION FORM
BIRNEY MIDDLE SCHOOL

CHILD'S NAME: _____ GRADE: _____

PARENT NAME: _____ PHONE: _____

1. The above named student must take _____during school hours.
(name of medication)

2. _____ should be administered at _____
(exact dosage) (time[s] of day)

3. Effects of medication on student: _____

_____

_____

4. Effects of medication that indicate further contact with physician is needed:

_____

_____

_____

5. Physician's Name: _____
6. Physician's Signature: _____
7. Date: _____
8. Office Phone Number: _____

_____

I, the parent/guardian of the above named student, request that school personnel administer this medication following the physician's directions. I assume full responsibility and hereby release the Board of Education, Southfield Public Schools, and all school personnel from all liability in connection with this request.

_____ _____
Parent Signature Date

- All medications (over the counter and/or prescription) that need to be dispensed through the counseling center must have this form on file.
- All medications must be housed in the counseling center. Students should not carry medications on their persons, in book bags, in purses, etc.
- This form must be signed by a doctor.
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