

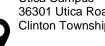
AUTHORIZATION FOR MEDICATION

State guidelines require that written permission from a parent/guardian be on file in the school office before medication will be administered to a student. Prescription medication must be in its original container with the original pharmacy label attached. In an emergency a call is made to 911 and to the student's parent/legal guardian.

Student Name:		Date of Birth:							
Grade:									
Physician Name: Phone Number:									
Physician Address:									
Name of Medication: _									
(Optional) Reason/Diag	nosis for Medic	ine:							
Form of Medication/Tre									
Tablet/Capsule _	Liquid	Inhaler	Injection	Nebulize	r	_ Other	r		
INSTRUCTIONS;									
Dose:			Time:	:					
	Duration:	Daily	Tempor	aryAs	s Need	ded			
Restrictions and/or in I request that my according to Huron Aca	child be assisted	d by authorize						ation at	school
I request that my	child be allowed	d to self-admi	nister the above	e medication	acco	rding to	schoo	ol policy	•
This student is ca (2nd grade and up can a					er				
If, based on their observ and its personnel from a exists.									
Signature:		Relationship	p:		_Date	:			
Physician Signature:					Date	::			

Utica Campus (586) 690-8180 Fax: (586) 329-4163

> Metro Campus (586) 446-9170 Fax: (586) 446-9173



Utica Campus 36301 Utica Road Clinton Township, MI 48035

Metro Campus 11410 Metropolitan Parkway Sterling Heights, MI 48312



Joshua Sobczak Superintendent

Paula Bremerkamp Principal

Lisa Lane Assistant Principal

Jason Robinson Assistant Principal