**ARMADA MIDDLE SCHOOL**
**23550 Armada Center Road**
**Armada, MI 48005**

**Phone: 586 784 -2500**
**Fax: 586 784-8650**

## REQUEST TO ADMINISTER MEDICATION

This form must be completed by parent/legal guardian and kept in the office. Parent/legal guardian must bring all medication to the school. All medication must be in the original container, clearly labeled, indicating the student's name, prescription number, medication name, dosage, date issued, doctor's name, pharmacy name, address and phone number.

**TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:**

_____ _____ _____
Student Name Grade Date

_____
Address City State Zip Code

_____ _____
Home phone Work Phone

I understand that it is the sole responsibility of my child to report to the office for his/her medication. I further understand that it is my responsibility to notify the school of change or discontinuation of the medicine. I agree to renew this application at the beginning of each school year and/or when there is a change in medication. **Please remember that all medication must be picked up by the last day of school or it will be thrown out.**

**Signature of Parent/Legal Guardian:**_____

**TO BE COMPLETED BY PHYSICIAN:**

**Name of Medication:**_____

Dosage:_____ Frequency:_____

Time Given:_____ Duration :_____

Prescription:_____ Non-Prescription:_____

Self-Administer and/or Self Possess: Yes_____ No_____

By saying yes, I represent that the student is capable and responsible to self-possess and/or self-administer this medication.

**PHYSICIAN SIGNATURE:**_____ **DATE:**_____