

**PARENTS:** Please return this form to the Meads Mill office when your student needs to take prescription or over the counter medication.

**NORTHVILLE PUBLIC SCHOOLS  
Meads Mill Middle School  
16700 Franklin Road  
Northville, MI 48168**

**PERMISSION TO ADMINISTER PRESCRIBED AND OR OVER THE COUNTER MEDICATION.**

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Purpose of Medication \_\_\_\_\_  
\_\_\_\_\_

- Prescription(s):
1. Name of Medication \_\_\_\_\_  
Dosage \_\_\_\_\_ Frequency \_\_\_\_\_  
Time of Administration \_\_\_\_\_
  
  2. Name of Medication \_\_\_\_\_  
Dosage \_\_\_\_\_ Frequency \_\_\_\_\_  
Time of Administration \_\_\_\_\_
  
  3. Name of Medication \_\_\_\_\_  
Dosage \_\_\_\_\_ Frequency \_\_\_\_\_  
Time of Administration \_\_\_\_\_

Comments regarding prescription (diagnosis or reason for taking medications, adverse reactions, precautions, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name (Printed) \_\_\_\_\_ Telephone \_\_\_\_\_

Physician's Address \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize appropriate school personnel to administer prescribed medication to \_\_\_\_\_. I understand that the medication will be administered as per the directions of above named physician. I will notify the school of changes or discontinuation of this medication(s).

\_\_\_\_\_  
Parent/Legal Guardian  
medform.09

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone