Michigan School for the Deaf Health Center

Medication Authorization Form

This form must be filled out and signed by your doctor and parent/guardian if your child takes prescribed medication on a daily or as needed basis.

Physicians Order

This section must be completed by the physician.

Patient Name: _____ Date of Birth: _____

Medication(s), Dose, Frequency

Medication	Dosage	Frequency

Length of time medication should be administered. From: _____ To: _____

Physician's Signature: _____ Date: _____

Physician's Phone Number: _____

Parent/Guardian Authorization

This section must be completed by the parent or guardian.

Student's Name: _____

I request the Michigan School for the Deaf staff administer my child's medication as ordered by this physician. I agree not to hold the Michigan Department of Education, the Michigan School for the Deaf, or their personnel responsible for complications related to this medication.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Form Submission

Submit the completed form to the MSD Health Center via mail to 1235 W. Court Street, Flint, MI 48503 or via fax to 810-257-1408. For questions call 810-257-1448.