Extended Day Program
Ann Arbor Public Schools
Medication Administration Form
Authorization for Carrying and Self-administration of Medication

AAPS Extended Day Program requires written authorization by a Physician, the Parent or Guardian and the EDP Administrator in order to permit students to carry and self-administer medications, including over-the-counter medications. *The student must be able to responsibly manage the medication.* **This form authorizes carrying and self-administration of medication during EDP program hours**.

PHYSICIAN'S ORDER FOR MEDICATION:

Student Name____ Date________________________

Address____ Date of Birth__________________

Diagnosis____

Name of medication(s)____

Time(s) of administration and dosage____

Relevant side effects, if any____

Other suggestions____

The length of time that the medication shall be administered shall be one school year, from September to August. All medication authorizations must be renewed at the beginning of each school year.

________________________ ___________ ____________________________ __________
Physician Signature Date EDP Administrator Date

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Physician's Address

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I hereby request that my student be **permitted to carry and self-administer** the above medication at school. I understand that self-medication of medicines at school is contingent upon the permission of the EDP Administrator and the responsible management of the medication by the student. I will notify the EDP Office in writing if this medication is to be discontinued. If the administration of the medication needs to be otherwise changed, I will resubmit an Authorization for Carrying and Self-Administration of Medication form.

____________________________________ __________________
Parent/Guardian Signature Date

7/2021 ah