

Permission form for Prescribed Medication

St Joseph School
201 E Cass Street
St Johns MI 48879
(989) 224-2421 FAX (989) 224-1900

Date from received by the school: _____

Student: _____ Date of Birth or age: _____

Grade: _____ Teacher/Classroom: _____

To be completed by the physicians or authorized prescriber

Name of medication: _____

Reason for medication (OPTIONAL) _____

Form of medication/treatment:

Tablet/capsule Liquid Inhaler Injection Nebulizer Other _____

Instructions (Schedule and dose to be given at School): _____

Start: date form received Other dates: _____
Stop: end of school year Other date/duration: _____
 For episodic/emergency events only

Restrictions and/or important side effects: None anticipated
 Yes, Please describe: _____

Special storage requirement: None Refrigerate
Other: _____

This student is both capable and responsible for self-administering this medication:
 No Yes-Supervised Yes-Unsupervised

This student may carry this medication: No Yes

Please indicate if you have provided additional information:
 On the back side of this form As an attachment

Date: _____ Signature: _____

Physician's Name: _____
Address: _____
Phone Number: _____

To be completed by parent/guardian

I request that (name of child) _____ received the above medication at school according to standard school policy.

I request that (name of child) _____ be allowed to self-administer the above medication at school according to the school policy.

Date: _____ Signature: _____ Relationship: _____