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:_____