

**Stockbridge Community Schools**

**Permission Form for Non-prescription Medications**

**Smith Elementary** 517-851-7735 Fax: 517-851-4721

**Heritage Elementary** 517-851-8600 Fax: 517-851-4676

**Junior/Senior High** 517-851-7770 Fax: 517-851-9446

Student Name: \_\_\_\_\_

Date Form Received by School: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

To be completed by parent/guardian:

Name of Medication: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Form of Medication/Treatment:

Tablet/Capsule    Liquid    Other \_\_\_\_\_

Instructions (Schedule and dose to be given at school) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Start Date of Medication: \_\_\_\_\_ End Date of Medication: \_\_\_\_\_

Restrictions and/or important side effects:

Special Storage instruction    None    Refrigerate    Other \_\_\_\_\_

\_\_\_\_\_

Please indicate if there is any additional information needed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_ Parent/guardian signature: \_\_\_\_\_