STOCKBRIDGE COMMUNITY SCHOOLS

Permission Form for Prescribed Medications

Phone: **Smith 517-851-7735** **Fax: 517-851-4721**
Heritage 517-851-8600 **Fax: 517-851-4676**
Jr/Sr. High 517-851-7770 **Fax: 517-851-9446**

Student: _____ Date of Birth: _____

Grade: _____ Teacher: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I request that my child receive the listed medication at school according to standard school policy.

Signature: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER:

Name of Medication: _____

Reason for medication: _____

Form of Medication: _____Tablet/capsule _____Liquid _____Inhaler _____Nebulizer

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

_____

Start Date: _____ End Date: _____

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

_____

Special Storage Instructions: _____ 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 of the form _____ As an attachment

Physician Signature: _____ Date: _____

Physician's Name: _____

Address: _____

Phone #: _____ Fax #: _____
