PUBLIC SCHOOLS OF PETOSKEY **Board Policy 2780**

PERMISSION FORM FOR PRESCRIBED MEDICATION

School: _____ Date form received by the school: _____

Student: _____ Date of Birth or Age: _____
(Name)

Grade: _____ Teacher/Classroom: _____

TO BE COMPLETED BY THE PHYSICIAN 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 _____

Restrictions and/or important side effects: ☐ None Anticipated ☐ Yes

If yes, please describe _____

Special Storage Requirements: ☐ None ☐ Refrigerate

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

Physician's Signature _____ Date: _____

CONTINUED ON THE BACK

TO BE COMPLETED BY PARENT/GUARDIAN

I request that _____ receive the above medication at school
(Name of Child)
according to standard school policy.

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

Parent/Guardian Signature: _____ Date: _____

Relationship: _____ This information expires on June 30, _____

School Fax Number: _____

Physician's Signature Date:

Print Physician's Name