Permission Form for Medication

Skeels Christian School
3956 North M-18
Gladwin, MI 48624

Date form received by the school: ____________________

Student: ______________________________ Date of Birth, or age: __________

Grade: ______________ Teacher/Classroom: ____________________

To be completed by the physician if the medication DOES NOT have a prescription label;
To be completed by a parent/guardian if the medication HAS a prescription label.

Name of medication: ____

Reason for medication: ________________________________

Form of medication: () Tablet/capsule () Liquid () Inhaler () Injection () Nebulizer

() Other____________

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

1. Start: () date form received Other dates: ____________
2. Stop: () end of school year Other date/duration: ________
3. For episodic/emergency events only: ()

Restrictions and/or important side effects:
() None anticipated

() Yes, Please describe: ____

Special storage requirements: () None () Refrigerate Other________

Physician's Name:____________________________
Address:____
Phone Number:__________________

Date:______________ Signature_________________________
Physician or Parent/Guardian

To be completed by parent/guardian

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, if school policy allows

I request that ______________ receive the above medication at school according to standard school policy.
name of child

I request that ______________ be allowed to self-administer the above medication at school according to standard school policy.

Date:________ **Signature:**____________________ **Relationship:**__________