

# Permission Form for Prescribed Medication

St. Mary's Preparatory, 3535 Indian Trail, Orchard Lake, MI 48324

Fax – 248-683-1740

Date form received by the school: \_\_\_\_\_

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

D.O.B: \_\_\_\_\_

Grade: \_\_\_\_\_

First Hour Teacher: \_\_\_\_\_

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## To be completed by the physicians or authorized prescriber:

Name of the 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 \_\_\_\_\_

End:         End of school year       Other date/duration \_\_\_\_\_

For episodic/emergency use only

Restrictions and/or side effects:       None anticipated

Yes, please describe: \_\_\_\_\_

Special storage requirements:       None       Refrigerated

Other: \_\_\_\_\_

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Physician's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

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## To be completed by parent/guardian (This Section Only)

I request that my son/student, \_\_\_\_\_, receive the above medication at St. Mary's Preparatory according to school policy.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship: \_\_\_\_\_