St. Joseph the Worker School

2091 North Winn Road
Mt. Pleasant MI 48858
989.644.3970
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Permission Form for Prescribed and Non-Prescribed Medication

Name of Student _____ DOB _____

Name of Medication _____

Reason for Medication _____

Form of Medication

__ Tablet/Caplet __ Liquid __ Inhaler __ Nebulizer __ Injection __ Other

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

_____

Use back of form for more specific directions or restrictions.

Start Date _____ Stop Date _____ Annual Renewal _____

Restrictions and/or important side effects: _____

__ Refrigerate __ Shake **Other important information** _____

_____

To be completed by parent/guardian:

I give permission for my child _____ to receive the above medication while at school. I have been given a copy of the school medication guidelines and understand them. I am also aware that a new form must be completed each time there is a change in drug, dose, or time to be given and is my responsibility to make the school office aware of this. **I must also complete this form for any over-the-counter medication** and supply that medication**, including cough drops**. **Medication bottles must be correctly labeled** (ask the pharmacy for an extra bottle for school use.)

Parent/Guardian Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN:

Physician Signature _____

Physician Printed Name _____

Address _____ Phone _____