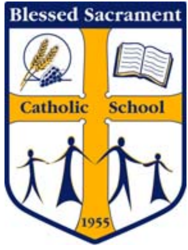

Permission Form for Prescribed and Non-Prescribed Medication

Blessed Sacrament Catholic School,
3109 Swede Avenue, Midland, MI 48642
835-6777 835-2451 Fax

2016-2017 School Year

Student_______________________________ Date of Birth ________________ Grade____

To be completed by the physicians 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)*____

- Episodic/emergency events only
- Start Medication ______________*(Date)* Stop Medication__________________*(Date)*
- Restrictions and/or important side effects
    - None anticipated
    - Yes, Please describe ____

      ____
- Special storage requirements:
    - None
    - Refrigerate
    - Other _____________________________________
- Please indicate if you have provided additional information
    - See reverse of this form
    - See attachment

Date:______________________________Signature:____
(Physician or authorized prescriber)
Physician's Name______________________
Address______________________________
Telephone Number_____________________

To be completed by parent/guardian

I request that (name of child)___________________receive the above medication(s) at school according to standard school policy. I understand I must provide medication(s).

Date____________Signature______________________________Relationship to child___________________