



4800 Lapeer Road  
Kimball, MI 48074  
Phone: (810) 982-7210  
Fax: (810) 982-0679

## Medication Permission Form (For all over-the-counter and/or prescribed medications.)

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

Date of Birth: \_\_\_\_\_ Grade/ Teacher: \_\_\_\_\_

### To be completed by the physician:

**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: \_\_\_\_\_  
For Episodic/Emergency events only \_\_\_\_\_

Restrictions and/or important side effects: \_\_\_\_\_ None anticipated    \_\_\_\_ Yes (please describe below).

Special storage requirements: None \_\_\_\_\_ Refrigerate \_\_\_\_\_ Other \_\_\_\_\_

The student is both capable and responsible for self-administering this medication:  
\_\_\_\_ No    \_\_\_\_ Yes - Supervised    \_\_\_\_ Yes - Unsupervised

Physician's Name: \_\_\_\_\_

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

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

### To be completed by the parent/guardian:

I request that (student's name) \_\_\_\_\_ receive the above medication at school according to standard school policy.

I request that (student's name) \_\_\_\_\_ be allowed to self-administer the above medication at school according to the school policy.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_