PERMISSION FORM FOR PRESCRIBED MEDICATION

ALANSON PUBLIC SCHOOLS
7400 NORTH STREET
ALANSON, MI 49706

PHONE: 231-548-2261
Central FAX: 231-548-2132
K-12 FAX: 231-548-2165

Date form received by the school: ____________________

STUDENT____________________ DATE OF BIRTH ____________________
ADDRESS ____________________GRADE ____________________
TEACHER____________________

To be completed by the physician or authorized prescriber:

NAME OF MEDICATION:____________________
Reason for medication (OPTIONAL) ____________________
Form of medication/treatment:

- **Tablet/capsule**
- **Liquid**
- **Inhaler**
- **Injection**
- **Other** ____________________

Instructions (Time and dosage to be given at school):____________________
____

Starting date: ____________________
Ending date: ____________________
Other dates:____________________
Restrictions and/or important side effects:

- **None anticipated**
- **Yes, Please describe:** ____________________

__ ____________________
____

Special storage requirements:

- **None**
- **Refrigerate**
- **Other** ____________________

This student is both capable and responsible for self-administering this medication:

- **No**
- **Yes - supervised**

Please indicate if you have provided additional information:

- **On the back side of this form**
- **As an attachment**

DATE____________________ **PHYSICIAN SIGNATURE** ____________________
ADDRESS ____________________**PHONE NUMBER** ____________________

TO BE COMPLETED BY PARENT/GUARDIAN

I request that (name of child) ____________________ **receive/or self-administer under supervision, the above medication at school according to standard school policy.**

DATE:____________________ **SIGNATURE:** ____________________

RELATIONSHIP: ____________________