Forest Elementary School
19400 Hampton
Riverview, MI 48193
Phone: (734) 479-2550 Fax: (734) 479-2912

Permission Form for Prescribed Medication

School: _____ Date form received by the school: _____

Student: _____ Date of Birth: _____

Grade: _____ Teacher/Classroom _____

To be completed by the physician or authorized prescriber

Name of medication: _____

Reason for medication: _____

Form of medication/treatment:
{ } Tablet/capsule { } Liquid Inhaler { } Injection { } Nebulizer { } Other _____

Time and Dose to be given at school: _____

If p.r.n., list symptoms/conditions under which medication is to be given: _____

_____

Special Instructions: _____

Restrictions and/or important side effects: { } None anticipated { } Yes, Please describe:

_____

Special storage requirements: { } None { } Refrigerate

Start: { } Date form received Other dates: _____
Stop: { } End of school year Other date/duration: _____

This student is both capable and responsible for self-administering this medication
{ } No { } Yes-Supervised { } Yes –Unsupervised**

This student may carry this medication: { } No { } Yes**
****(If Yes, please complete the back of this form.)**

Physician's Name: _____

Address: _____

Phone Number: _____ Fax: _____

Physician's Signature: _____ **Date:** _____

Physician's Stamp

To be completed by parent/guardian

I request that (name of child) _____receive the above medication at school according to standard school policy and for the physician staff and school staff to share information needed to assist my child with his/her health and medication needs.

Parent/Guardian Signature: _____

Relationship to Student: _____ **Date:** _____

Medication Prescriber/Parent Authorization Form for Self-Administration/Self-Possession

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate and self-determined administration. For medication other than inhalers, only that day's supply of medication is to be carried. The school district recommends that spare medication, properly labeled in its original container, be kept in the clinic/office in case the student runs out or forgets the medication. The building administrator may discontinue the student's self-administration privilege upon advanced notice to the parent/guardian. **The student must carry a copy of this form at school.**

Student Name: _____ Birth Date: _____ School Year: _____

To be completed by physician/licensed prescriber:

Start Date: _____ Stop Date: _____

Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions

*Routes: oral (pill/capsule/chewable, liquid) ~ inhaled (inhaler, nebulizer) ~ topical (eye/ear drop, ointment, etc.) ~ injection ~ other (list)

List minimal frequency between doses (especially if p.r.n.): _____

If p.r.n., list symptoms/conditions under which medication is to be given: _____

The student is capable of { } self-administering { } self-possessing the above medication(s)

_____ _____ _____
Physician's signature Date Physician's Printed Name

Physician's Phone #: _____ Fax #: _____
Address: _____

To be completed by parent/guardian:

I request and give permission for my child (named above) to: { } self-administer { } self-possess the above medication according to school district policy and for the physician staff and school staff to share information regarding my child's health and medication needs.

_____ _____
Parent/guardian signature Date

To be completed by student:

I agree to:

1. Never share my medication with another person.
2. Carry the medication in its original, properly labeled prescriptive/over the counter container.
3. Take medication only at the prescribed time/frequency and dose.
4. Keep a copy of this form and back up medication in the school office/clinic.

I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parents/guardians, and the privilege(s) of self-administration/self-possession denied.

_____ _____
Signature Date