Permission Form for Prescribed Medication

East Grand Rapids High School
2211 Lake Drive SE
Grand Rapids, MI 49506-3091
Phone: 616-235-7555
Fax: 616-942-0706

Date form received by school:_____

Student Name: _____
Grade: _____
Date of Birth:_____
Address: _____
Home Phone: _____
Father's Work Phone: _____
Mother's Work Phone: _____

To be completed by the Physician or Authorized Prescriber

Name of medication:_____

Dose:_____

Prescribed Time:_____

Form of medication:

☐ Tablet ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer

Restrictions and/or important side effects:

☐ None anticipated

☐ Yes. Please describe:_____

_____

(Additional information can be documented on reserve side or attached to this document)

☐ For episodic/emergency events only

Start:_____ date form received Other dates_____

Stop:_____ end of school year Other dates_____

Physician's Signature_____

Physician's Phone _____

To be completed by the Parent/Guardian

☐ I request that_____ receive the above mediation at school according to standard school policy.

☐ I request that _____ be allowed to self-administer the above medication at standard school policy.

Date_____ Signature_____ Relationship _____

Parent must bring medications to the office in the original, properly labeled prescription bottle. Make sure time and dosage are clear.