

Permission Form for Prescribed Medication  
St Paul Lutheran School-6094 Westside Saginaw Road-Bay City, MI 48706

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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***This section is to be completed only by the physician or authorized prescriber***

\_\_\_\_\_  
Name of Physician/Authorized Prescriber (Please Print)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Name of Medication:

\_\_\_\_\_  
Reason for Medication:

Form of Medication: Check the appropriate type(s)

Tablet/Capsule

Inhaler

Nebulizer

Liquid

Injection

Other: \_\_\_\_\_

**Specific instructions for administering the above medication**

Start date for medication: \_\_\_\_\_

End date for medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Schedule: \_\_\_\_\_

*Inhalers only:* Is this student both capable and responsible for self-administering?

No

Yes-supervised

Yes-unsupervised

*Inhalers only:* May this student carry this medication on his/her person?

No

Yes

Any Restrictions and/or side effects: \_\_\_\_\_

Any special storage requirements: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician/Authorized Prescriber      Date

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***To be completed by parent/guardian***

I request that \_\_\_\_\_ receive the above medication at school according to the above instructions and standard school policy. (See parent handbook for policy)

*Inhalers only:* I request that \_\_\_\_\_ be allowed to self-administer the above medication at school according to the above instructions and standard school policy. (See parent handbook for policy)

*Inhalers only:* I request that \_\_\_\_\_ be allowed to carry the above medication on his/her person at school according to standard school policy. (See parent handbook for policy)

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date