

PERMISSION FORM FOR NON-PRESCRIBED MEDICATION

**VALLEY LUTHERAN HIGH SCHOOL
3560 MCCARTY ROAD
SAGINAW, MI 48603**

Date form received by the school: _____

Student: _____

Grade _____

Date of Birth _____

To be completed by parent:

Name of medication: _____

Reason for medication:(OPTIONAL) _____

Form of medication/treatment:

Tablet/capsule Liquid 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: _____

Special storage requirements: None

Other: _____

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

Please indicate if you have provided additional information:

On the back side of this form As an attachment

To be completed by parent/guardian

I request that (name of child) _____ receive the above medication at school according to standard school policy.

I request that (name of child) _____ be allowed to self-administer the above medication at school according to the school policy.

Date _____ Signature _____ Relationship _____