

**PERMISSION FORM FOR PRESCRIBED MEDICATION**

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

Date form received by the school: \_\_\_\_\_

Student: \_\_\_\_\_

Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

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**To be completed by the physicians or authorized prescriber**

Name of medication: \_\_\_\_\_

Reason for medication: (OPTIONAL) \_\_\_\_\_

Form of medication/treatment:

Tablet/capsule    Liquid    Inhaler    Injection    Nebulizer    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: \_\_\_\_\_

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Special storage requirements:                       None                       Refrigerate

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

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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

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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**Physician's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

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**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** \_\_\_\_\_