DEARBORN HEIGHTS SCHOOL DISTRICT NO. 7
20629 ANNAPOLIS STREET
DEARBORN HEIGHTS, MI 48125
(313) 203-1000 phone (313) 278-1413 fax

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:** _____