Grand Haven Area Public Schools

PERMISSION FORM FOR SELF-ADMINISTRATION OF PRESCRIBED MEDICATION

Building:_____ Date form received by the school:_____

Student:_____ Date of Birth:_____

Grade:_____ Teacher/Classroom:_____ Phone:_____

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 dates/duration:_____

Restrictions and/or important side effects: ☐ None Anticipated

☐ Yes. Please describe:_____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other:_____

This students is both capable and responsible for self-administering this medication:

☐ No ☐ Yes

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:_____

Physician's Name:_____

Address:_____

Phone Number:_____

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:_____