Prescription Medication Permission Form

(use a separate form for each prescription)

Name:____

Date of Birth:____________**Grade:**________**School Year:**__________

This section must be completed by the physician's office.

Name of Medication:____

Start Date:______________________ **Stop Date:**_________________________

Reason for Medication (optional):____

Form of Medication/Treatment:____

Tablet Capsule Inhaler Injection Nebulizer Topical Drops Other (describe)

Instructions (the time and dosage to be given at school):

NOTE: The time and dosage listed here should match the instructions on the medication package.

____

____

Restrictions and/or important side effects:

None anticipated

Yes, please describe:____

Physician's Signature:____**Date:**____________________

Physician's Name:____

Physician's Address:____

Physician's Phone Number:_______________________**Physician's Fax Number**____________________

To be completed by parent/guardian:

I request that ____**(name of child) receive the above medication/treatment at school according to standard school policy and I agree with the statement below. I understand that I must deliver the medication to the school office and that it cannot be sent with a student.**

Signature:________________________________ **Date:**____________**Relationship:**___________________

I hereby request and authorize the school staff to administer the prescribed medication as directed by our physician. Further, I release Williamston Community Schools and shall indemnify said school district from any liability or damage which may result to my child from the administration of said medication as prescribed by our physician.

Williamston Middle School
3845 Vanneter Road
Williamston, MI 48895
Phone: 517-655-4668
Fax: 517-655-7502