Permission Form for Prescribed Medication
Avondale School District

MAIN LINE: 248-537-6700 **FAX: 248-537-6705**

Student: _____

Grade/Teacher: _____

This section to be completed by the physician or authorized prescriber:

Name of medication: _____

Reason for medication: (OPTIONAL) _____

Form of medication/treatment:

❑Tablet/Capsule ❑Liquid ❑Inhaler ❑Injection ❑Nebulizer ❑Other _____

Schedule and dose to be given at school: _____

_____

Date to begin medication: _____ Date to end medication: _____

Restrictions and/or important side effects:

❑None anticipated

❑Yes – please describe important side effects: _____

_____

Special storage requirements: ❑None ❑Refrigerate ❑Other: _____

This student is both capable and responsible to self-administer this medication:

❑No ❑Yes – Supervised

Indicate if you have provided additional information ❑on the back side of this form or ❑as an attachment.

Physician's Signature: _____ Date: _____

Please Print: Physician's Name: _____

Address: _____

Phone Number: _____

This section to be completed by Parent/Guardian:

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

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

Date: _____ Signature: _____ Relationship to child: _____

Received by _____ (Avondale staff member) Date: _____