Father Marquette Catholic Academy

Permission Form for Prescribed/Non-prescribed Medication

Date formed received by school: ____________________
Student:____ DOB:________________Grade:__________

To be completed by the physician or authorized prescriber

1. Name of medication:____
2. Reason for medication (opt):____
3. Form of medication/treatment:
Tablet/capsule____ Liquid____ Inhaler____ Injection____ Nebulizer____ Other_________________
4. Schedule and dose to be given at school:
____
____

- Start date: _____date form received -OR- ____________other date
- Stop date: _____ end of school year -OR- ____________other date
- _____ For episodic/emergency events only
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5. Restrictions and/or important side effects:
_____None anticipated
_____Yes. Please describe____
____
6. Special storage requirements:
_____None _____Refrigerate Other:____
7. This student is both capable and responsible for self-administering this mediation:
_____No _____Yes-Supervised _____Yes-**Un**supervised
8. This student may carry this medication: _____No _____Yes
9. Please indicate if you have provided additional information:
_____On the back of this form ______As an attachment

Date:________________ **Signature**:____
Physician's Name:____
Address: ____
Phone Number: ____

To be completed by the 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 mediation at school according to the school policy.

Print:____

Signature:____Date:_____________Relationship:______________