ST. PETER LUTHERAN SCHOOL HEALTH SERVICE FORM

PERMISSION FORM FOR PRESCRIBED MEDICATION

Michigan law requires schools to have a written physician's order
and parent/guardian authorization for administration of medication.

Date from received by the school: _____

Student: _____ Birthdate: _____

School: _____ Grade: _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Reason for medication: _____

Name of medication: _____

Form of medication/treatment:

___ Tablet/Capsule ___ Liquid ___ Inhaler ___ Injection ___ Nebulizer ___ Other: _____

Instructions (schedule & dose to be given): _____

_____

Start: ___ date form received Other date: _____

Stop: ___ end of school year Other date/duration: _____

Restrictions and/or important side effects:

___ None anticipated.

___ Yes (please describe) _____

_____

SPECIAL AUTHORIZATION FOR INHALERS, DIABETICS, and EPI-PENS

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

Please indicate if you have provided additional information: ___on back ___as attachment

Date: _____ Physician's Signature: _____

TO BE COMPLETE BY THE PARENT/GUARDIAN:

I give permission for (name of child) _____ to receive the above medication at school & school sponsored functions and will not hold the school or Board of Education or its personnel responsible for complications related to the medication. I understand this health information can be shared when it is educationally relevant for academic progress, necessary for providing health services including emergency care, or essential to ensure the protection of other students or school personnel.

Date: _____ Signature: _____ Relationship: _____