Permission Form for Prescribed Medication and All Over-the-Counter Medication (including Ointments and Creams)

School: ______________________________
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Howell Public Schools

Date form received by the school: ______________

Student: ______________________________ Date of Birth or Age: ______________________

Grade: ______________ Teacher/Classroom: ______________________________

To be completed by the physicians or authorized prescriber

Name of medication: ______________________________

Reason for medication: ______________________________

Form of medication/treatment: ______________________________

☐ Tablet/cap ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer
☐ Other ______________

Specific instructions: (Dose/frequency to be given at school): ______________________________
____

Start: ☐ date form received Other dates: ______________________
Stop: ☐ end of school year Other date/duration: ______________________
☐ For episodic/emergency events only

Restrictions and/or important side effects: ☐ None Anticipated ☐ Yes. Please Describe: ______________
____

Special storage requirements: ☐ None ☐ Refrigerate

Other: ______________________________

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 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: ______________