# Belding Area Schools

## Permission Form for Prescribed Medication

Date form received by the school: _____

Student: _____ Date of Birth, or age _____

Grade: _____ Teacher/Classroom: _____

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**To be completed by the physician or authorized prescriber**

Name of medication:

_____

Reason for medication:

_____

Form of medication/treatment (please circle)

Tablet/capsule Liquid inhaler injection Nebulizer Other _____

Instruction (Schedule and dose to be given at school):

_____

_____

Start: _____ date form received Other dates: _____

Stop: _____ end of school year Other dates/duration: _____

For episodic/emergency events only ___

Restrictions and/or important side effects: ___None anticipated ___Yes (describe below)

Description:

_____

_____

Special storage requirements: ___ None ___ Refrigerate ___ Other (see below)

Storage requirements:

_____

**FOR EMERGENCNY/LIFE SAVING MEDICATION ONLY (epi pens, Inhaler, etc…..)**

This student is both capable and responsible for self-administering this medication:

___ No ___ Yes – Supervised ___ Yes – Unsupervised

This student may carry this medication: ___Yes ___ No

Please indicate if you have provided additional information:

___On the back side of this form ___ As an attachment

Date: Physicians Signature:

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Physician's Name:

_____

Address:

_____

Phone Number:

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**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: _____ Parent Signature: _____