St. Paul Lutheran School
Permission Form for Prescription and Non-Prescription Medication

School: ST. PAUL LUTHERAN
402 S. BALLENGER HWY.
FLINT, MI 48532

Date: _____

Student: _____ **Date of Birth:** _____

Grade: _____ **Teacher/Classroom:** _____

To be completed by the physician:

Name of Medication: _____

Form of medication/treatment:

○ Tablet/capsule ○ Liquid ○ Inhaler ○ Injections ○ Nebulizer ○ Other _____
Instructions (Schedule and dose 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: _____

For Inhaled Asthma Medication:

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

Physician's Name/Signature: _____ Date: _____
Address: _____
Phone Number: _____

To be completed by parent/guardian:

I request that (name of child)_____receive the above medication at school according to school policy and procedure.

Date: _____ Signature: _____ Relationship: _____