



# Van Buren Public Schools

555 West Columbia Ave.  
Belleville, MI 48111  
Telephone 734-697-9123  
Fax 734-697-6385

## Permission Form for Medications in School

Date Form Received : \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date of Birth or Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher/classroom: \_\_\_\_\_

### To be completed by physician or copied from label of prescribed medication

Name of Medication: \_\_\_\_\_

Reason for medication (optional): \_\_\_\_\_

Prescription                       Non-Prescription

Form of medication:  Tablets/capsules     Liquid     Inhaler     Other: \_\_\_\_\_

Instructions (dose and schedule): \_\_\_\_\_  
If dosage is "as needed" or "emergency only" specify symptoms and limits.

Begin administration of medication     Date of this form     Other date: \_\_\_\_\_

Stop administration of medication     At the end of the school year     Other date: \_\_\_\_\_

Restrictions and/or important side effects:

None anticipated     Yes (please describe): \_\_\_\_\_

Special storage requirements:  None     Refrigerate    Initial count of controlled medication: \_\_\_\_\_

### If student is to self-administer or carry medication, this section *MUST* be completed and signed by the prescribing physician.

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

May this student carry this medication?  Yes     No    Is this medication injected?     Yes     No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

**To be completed by Parent or Guardian:**    I request that \_\_\_\_\_ (Child's Name)

- receive the above medication at school, according to district policy
- (Check all that apply)  be allowed to self-administer this medication at school, according to district policy
- be allowed to carry this medication at school.

I authorize school personnel to contact the above physician with questions or concerns relative to this authorization and medication.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_