

Macomb Academy of Arts & Sciences
23211 Prospect St.
Armada, MI 48005
Phone: 586-784-2150
Fax: 586-784-8688

PERMISSION FORM FOR PRESCRIBED MEDICATIONS

Student Name: _____ Date form Received: _____

Birthdate: _____ Age: _____ Grade: _____

To be completed by physician or authorized prescriber:

Name of medication: _____

- Reason for medication: (OPTIONAL)

Dosage: _____ Time(s) to be given: _____

Circle one: Tablet/capsule Liquid Inhaler Injection Nebulizer Other: _____

Start date: _____ Stop date: _____

For episodic/emergency events only

- Restrictions and/or important side effects: None anticipated

Yes, Please describe: _____

- Special storage requirements None Refrigerate

Other: _____

Special Instructions

Student to carry inhaler at all times

Other, specify: _____

Please indicate if you have provided additional information:

On the back side of this form

As a attachment

Date: _____ Signature: _____

Physician's Name: _____ Phone Number: _____

Address: _____

Physician's signature: _____

To be completed by parent/guardian

I request that (Name of child) _____ receive the above medication at school according to standard school policy. I understand medications will be administered exactly as per the directions of my above named physician. I will notify the school of changes or discontinuance of this medication(s).

Date: _____ Signature: _____ Relationship: _____