

Permission Form for Prescribed Medication

Wavecrest Career Academy

633 Apple Avenue

Holland MI 49423

(616) 393-7662

(616) 393-7633 (fax)

Student: _____

Date form received by the school: _____

Grade: _____ Date of Birth: _____

To be completed by the physicians or authorized prescriber

Name of medication: _____

Reason for medication (optional) _____

Form of medication/treatment:

Tablet/Capsule Liquid Inhaler Injection Nebulizer Other _____

Instructions (schedule and dose to be given at school): _____

Start: date form received For emergency events only Other

Stop: end of school year other date/duration

Restrictions and/or important side effects:

Yes, please describe: _____

None anticipated

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 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 student) _____ receive the above medication at school according to standard school policy.

I request that (name of student) _____ be allowed to self-administer the above medication at school according to the school policy.

This also authorizes an exchange of information, as necessary, between the school and my child's health care provider.

Date: _____

Signature: _____

Relationship: _____