SOUTH LYON COMMUNITY SCHOOLS

Permission Form for Prescribed and/or Non-Prescribed Medication

Student _____ Date of Birth _____ ☐ Male ☐ Female Grade ____

Home Phone Number _____ Parent/Guardian work phone number _____

Date form received by school _____

To be completed by the Physician or Authorized Prescriber

Name of Medication: _____ Dosage: _____

Form of Medication: ☐tablet/capsule ☐ liquid ☐inhaler ☐injection ☐nebulizer ☐ other _____

Reason for medication (optional): _____

Time medication to be administered during school hours: _____ Dose: _____

Start medication: ☐Date form received ☐Other date (specify) _____

Stop medication: ☐End of school year ☐Other Date (specify) _____

☐For episodic/emergency use only Special Instructions: _____

Restrictions and/or possible side effects: _____

Storage Requirements: ☐None ☐Refrigerate ☐Other: _____

This student is both capable and responsible for self-administering this medication: ☐ No ☐ Yes-supervised ☐Yes-Unsupervised

Are there extenuating circumstances which make it necessary for the student to self-possess and self-administer this medication?
☐Yes ☐No

The student may carry this medication. If yes, parent must fill out Option 2 or Option 3 below. ☐Yes ☐ No

PLEASE NOTE: NARCOTICS AND CONTROLLED SUBSTANCES SUCH AS RITALIN MUST BE DISPENSED THROUGH THE SCHOOL OFFICE.

Please indicate if you have provided additional information: ☐On the back of this form ☐As an attachment

Physician/authorized prescriber signature: _____ Date: _____

Address: _____ Phone Number: _____

To be completed by parent/guardian

Choose one of the options below

OPTION 1

I request that _____ receive the above medication in the school office according to South Lyon Community Schools Administration of Medication Policy.

Parent/Guardian Signature _____ Relationship _____

Date _____

OPTION 2

Our physician has indicated that there are extenuating circumstances which make it necessary for _____ to self-possess and/or transport this medication. However, it is necessary for _____ to receive the above medication by school personnel according to the South Lyon Community Schools Administration of Medication Policy.

Parent/Guardian Signature _____ Relationship _____

Date _____

OPTION 3

Our physician has indicated that there are extenuating circumstances which make it necessary for _____ to self-possess and self-administer this medication. Therefore, I request that the building administrator approve this request and allow my child to self-possess and self-administer the above medication at school according to the South Lyon Community Schools Administration of Medication Policy, and I agree that the Procedures for Self-Possession and Self-Administration found in that policy will be followed.

Parent/Guardian Signature _____ Relationship _____

Student Signature _____ Date _____

Building Administrator Signature _____ Date _____