Grass Lake High School
11500 Warrior Trail
Grass Lake, MI 49240
Phone: 517-867-5570 Fax: 517-522-5490

PRESCRIPTION/NON PRESCRIPTION MEDICATION AUTHORIZATION AND INSTRUCTION FORM

Date form received at school_____
Student Name: _____ Date of birth:_____
Grade: _____ Teacher:_____

To be completed by the physician or authorized prescriber:

Reason for medication/condition:_____
Name of medication and **exact** doseage:_____
Form of medication/treatment:
❑ Tablet/Capsule ❑ Liquid ❑ Inhaler ❑ Injection ❑ Nebulizer ❑ Other: _____
Instructions (Schedule and dose to be given at school):
Start: ❑ date form received Other date: _____
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: _____

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 form ❑ As an attachment

Date: _____ Physician's Signature: _____

Physician's Name:
Physician's Address:
Physician's Phone Number:

To the school: Please report concerns about medications or disease to the above physician.

To be completed by parent/guardian:

I give permission for (name of child) _____ to receive the above medication at school according to school policy. I understand that medications are to be brought to school in their original containers with a current prescription label on them. Non prescription medications must have the child's name and dose written on the container itself.

Date: _____ Signature: _____ Relationship: _____