Genesee Christian School
Permission Form for Prescribed Medication

Student: ________________________ Date form received by the school: ______________

Date of Birth: __________________ Grade: ____________

To be completed by the physicians or authorized prescriber

Name of Medication: ____

Reason for Medication: (OPTIONAL) ____

Form of medication/treatment:
☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injections ☐ Nebulizer ☐ Other ________________
Instructions (schedule and dosage to be given at school): ___________________________________
____

Start Date: __________
Stop: __________
☐ **For episodic/emergency events only**

Restrictions and/or important side effects: ☐ None anticipated
☐ Yes. Please describe: ____
____

Special Storage Requirements: ☐ None ☐ Refrigerate
Other**:**____
____

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

Date: _______________ Signature:____
____
Physician' Name**:** ____
Address: ____
Phone Number: __________________

____

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 that all over-the-counter and prescription medication is to be turned in to the office and kept there at all times with the exception of asthma inhalers providing a note from the physician.

Date: ___________ Signature ________________________ Relationship: _________________