New Bedford Academy
6315 Secor Rd.
Lambertville, MI 48144

MEDICATION ADMINISTRATION PERMISSION FORM

Student Name: _____

Grade: _____ Teacher/Class: _____ Date of Birth _____

To be completed by the parent/guardian and or physician:

Name of medication: _____

Reason for medication (optional): _____

Form of medication:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other

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

_____

_____

_____

Start date:_____ Stop date: _____ As needed:_____ (per phone verification)

Restrictions and/or side effects:
☐ No, 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, but will be supervised

Physician Information: **(form is invalid without physician's signature)**

Physician's name (Please print): _____

Physician's signature: _____

Physician's 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 request that name of child)_____ be allowed to self-administer the above medication at school according to standard school policy.

Date: _____ **Signature:** _____ **Relationship:**_____