

Permission Form for Prescribed Medication

St. Elizabeth Ann Seton
280 East Square Lake Road
Troy, Michigan 48085
(248) 879-1310

Date form received: _____

Name: _____ Date of Birth: _____ Grade: _____

To be completed by the physician 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 event): _____

Date to begin medication: _____ Date to end medication: _____

Other dates: _____

For episodic/emergency events only

Restrictions and/or important side effects: None anticipated

Yes, please describe: _____

Special storage requirements: None Refrigerate

Other: _____

The child/teen is both capable and responsible for self-administering this medication:

No Yes-Supervised

Please indicate if you have provided additional information:

On the back side of this form As an attachment

Date: _____ Physician's Signature: _____

Physician's Name: _____

Address _____

City and State: _____

Telephone Number: _____

To be completed by parent/guardian: We request that _____
receive the above medication at the event according to standard policy.

I request that _____ be allowed to self-administer the
above medication at the event with supervision.

Date: _____ Signature _____