PLYMOUTH CHRISTIAN ACADEMY

43605 Joy Rd, Canton, MI 48187
Phone (734) 459-3505
FAX (734)459-9997
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OVER-THE-COUNTER *AND* PRESCRIBED MEDICATION PERMISSION FORM

Date Received by the school ____________

Student Name ____ DOB ___________ Grade ______________

Teacher/Classroom_______________________________ Allergies if any ____________________________________

Start Date: ______________ End Date______________

Medication Name	Dosage, Frequency and Indication for Medication. (Example; for headache, pain, etc.)	Form (Tablet/Liquid /Inhaler/ Injection/ect)	Storage Requirements	Self-Administration CIRCLE: Yes/ No **OR** Supervised	Student may carry this medication. **CIRCLE** Yes/No
				Y / N / S	Y / N
				Y / N / S	Y / N
				Y / N / S	Y / N
				Y / N / S	Y / N
				Y / N / S	Y / N

Additional Information if necessary*:*

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Physician Information

Physician Name: ______________________________________ Phone Number ____________________

Address ____ City ____________________

Physician Signature ____ Date ____________________

(Physician must sign this form for the school to administer any medications)

Parent /Guardian Authorization:

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.

Parent /Guardian Signature ____

Date________________________