PLYMOUTH CHRISTIAN ACADEMY

43605 Joy Rd, Canton, MI 48187
Phone (734) 459-3505
FAX (734)459-9997
www.plymouthchristian.org

Date Received by the school _____

PRESCRIBED MEDICATION PERMISSION FORM

Student Name _____ DOB _____ Grade _____
Teacher/Classroom_____

THIS AUTHORIZATION IS EFFECTIVE FOR THE TIME PERIOD STATED BELOW:

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:

_____

_____

Physician Authorization:

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 administration of the above medication(s) at school adhere to the instructions above and according to standard school policy.

Parent /Guardian Signature _____ Date_____