Montrose Community Schools
300 Nanita Drive ~ P.O. Box 3129
Montrose, MI 48457
Phone: 810.639.6131 ext 8800 OR 810.591.8800
Fax: 810.591.7268

Permission Form for Prescription and Non-Prescription Medication

School:	Date Received by School:
Student:	Date of Birth:
Grade:	Teacher/Classroom:

To be completed by physician or authorized prescriber(prescription) or by parent/guardian (non-prescription)

Name of Medication:	Reason (optional):	
Dosage:	Time to be Given:	
Is this medication for episodic/emergency events only (please circle)?	YES	NO
How should medication be given (please circle)?	Tablet/Capsule Liquid Inhaler Injection Nebulizer Other:	
Special Medication/Treatment Instructions:	Restrictions and/or Side Effects:	
Start Date:	Stop Date:	Other Date:
Special Storage Requirements (please circle):	NONE REFRIGERATE	OTHER:

Physician Statement (Completed by physician or authorized prescriber for prescription medication):

This student is both capable and responsible for self-administering this medication:	☐ Yes – Supervised ☐ Yes - Unsupervised ☐ No	
This student may self-carry this medication:	☐ YES	☐ NO
Physician's Name:		
Address:	Phone:	Fax:
Physician's Signature:	Date:	

Parent/Guardian Authorization to Administer Medication (must be completed by parent or guardian)

I request that the student named above receive the above medication at school according to standard school policy. I will notify the school immediately of changes or discontinuance of this medication or the prescribed treatment. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

I request that my child is allowed to self-administer the above medication according to standard policy:	☐ YES	☐ NO
I request that (name of student) may self-carry the above medication	☐ YES	☐ NO
Parent/Guardian Signature:	Date:	