Williamston Middle School
3845 Vanneter Road
Williamston, MI 48895
Phone: (517) 655-4668
Fax: (517) 655-7502

Prescription Medication Permission Form

(use a separate form for each prescription)

Name: ____ Grade: ____________________

Date of Birth: ____ School Year: ___________________

This section must be completed by the physician's office.

Name of Medication: ____

Start Date: ________________________________ Stop Date: _______________________________

Reason for Medication (optional): ____

Form of Medication/Treatment: ____
Tablet Capsule Inhaler Injection Nebulizer Topical Drops Other: _______________________________________

Instructions – please list the time and dosage to be given at school:
NOTE: The time and dosage listed here should match the instructions on the medication package.
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____

Restrictions and/or important side effects:
____
____
____

Physician's Signature: ____ Date: ________________

Physician's Name: ____

Physician's Address: ____

Physician's Phone Number: ___________________________ Fax Number: ______________________

I request that ________________________________ (name of child) receive the above medication/treatment at school according to the standard school policy and I agree with the statement below. I understand that I must deliver the medication to the school office and that it cannot be sent with a student.

Signature _____________________________________ Date: ______________________________

Relationship: _________________________________

I hereby request and authorize the school staff to administer the prescribed medications as directed by our physician. Further, I release Williamston Community Schools and shall indemnify said school district from any liability or damage which may result to my child from the administration of said medication as prescribed by our physician.