INKSTER PREPARATORY ACADEMY
MEDICATION PERMISSION FORM
(For all over-the-counter and/or prescribed medications.)

Student:_____

Date of Birth:_____ Grade/Teacher:_____

To be completed by the physician:

Name of Medication :

_____

Reason for Medication (optional)

_____

Form of Medication / Treatment:

_ Tablet/capsule __ Liquid Inhaler Nebulizer Other

Instructions (schedule and dose to be given at school):

Dose_____ Time to be given _____

__ Start:_____ End:_____
Date Date

Restrictions and/or important side effects: _____

____ Special storage requirements: None Yes (describe)

_____

Physician's Name:_____

Address:_____

Phone:_____ Date:_____

To be completed by the parent /guardian:

I request that (student's name)_____receive the above medication at school according to the school's policy.

Date_____ Signature_____ Relationship_____

It is the policy of Inkster Preparatory Academy that no discriminatory practices based on gender, race, religion, color, age, national origin, disability, height, weight, or any other status covered by federal, state or local law be allowed in providing instructional opportunities., programs, services, job placement assistance, employment or in policies governing student conduct and attendance. Any person suspecting discriminatory practice should contact the administrative office of Inkster Preparatory Academy.