NEW PARADIGM COLLEGE PREP ACADEMY
2450 S. Beatrice St.
Detroit, Michigan 48217
PH: 313.406.7060

Permission Form for Prescribe Medication

Student Name:____

Date form received by the School: ________/______/______ Received by:_________________________________

Grade:___________________ Birth Date:_____/_____/_____ Teacher:___________________________________

Instructions - TO BE COMPLETED BY THE PHYSICIAN		
Name of medication:		
Schedule/Dosage:		
**Medicine Type (circle one): Table / Liquid / Inhaler / Injection / Nebulizer / Other:		
Instructions:		
Start Date:	Stop Date:	☐ As Needed
Restrictions/Side Effects:		
Storage Requirements:		
Physician Name:	Phone Number:	

**** FORM MUST BE SIGNED BY THE PHYSICIAN –** A physician signature is required regardless of whether the medication is over-the-counter or prescription. So for example, this would include Tylenol, cold or allergy medicine etc.

Physician Name (Print):____

Physician Signature:____ Date:_____/_____/_____

TO BE COMPLETED BY PARENT/GUARDIAN

☐ I request that my child, ____ receive the above medication at school according to the standard school policy.

☐ I certify that my child, ____ is both capable and responsible, and I am requesting that he/she be allowed to self-administer the above medication at school according to the standard school policy.

Parent/Guardian Name (Print):____

Parent/Guardian Signature:____ Date:_____/_____/_____

Relationship to Student:________________________________ Phone Number:_________________________