

**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: _____ Date End: _____ 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.