MOMENTUM ACADEMY

PERMISSION TO ADMINISTER MEDICATION

This form must be filled out and signed by the doctor before medication will be administered to the student. **No exceptions can be made.**

Student:____________________________ Teacher:_________________________ Grade:_____

I hereby request that my child be administered his/her prescribed medication by the designated school personnel. I understand that the medication will be administered per the physician's order. I will notify the school of changes or discontinuation of this medication in writing.

Beginning Date:__________________________________ Ending Date:____________________

____

Parent / Guardian Signature ***Date***

PHYSICIAN'S DIRECTIONS
To be filled out by the physician only

1. Name of Medication:____

   Dosage:_______________________________ Frequency:__________________________

   Time to be administered:____

2. Name of Medication:____

   Dosage:_______________________________ Frequency:__________________________

   Time to be administered:____

____

Physician's Signature ***Date***

99 E Woodward Heights ◆ Hazel Park, MI 48030 ◆ Phone (248) 336-5600 ◆ Fax (248) 808-6478
www.ihavemomentum.org

Rev: 3-03-13