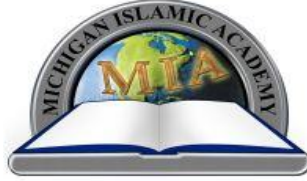


Michigan Islamic Academy
"...AND SAY: LORD, INCREASE ME IN KNOWLEDGE"
2301 Plymouth Road Ann Arbor, Michigan 48105
Phone: 734-665-8882 Fax: 734-665-9058



Medication Administration Permission Form

Student Name: _____

Date form received by the Academy: ____/____/____

Grade: _____ Birth Date: ____/____/____

Name of medication:

Dosage:

** Medicine Type (circle one): Tablet / Liquid / Inhaler / Injection / Nebulizer / Other:

Instructions:

Start Date: Stop Date: OR As Needed (via phone verification)

Restrictions/Side Effects:

Storage Requirements:

Physician Name: Phone Number:

****FORM MUST BE SIGNED BY THE PHYSICIAN – See below**

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.

REQUIRED SIGNATURES

IMPORTANT NOTE: 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 Signature: _____ Date: ____/____/____

Telephone: _____

Parent Signature: _____ Date: ____/____/____

Relationship (MUST be parent/guardian): _____

Telephone: _____