



Medication Administration Permission

Holy Family Catholic School

Phone (810)694-9072 FAX # (810)694-9405

School Year _____

Student's Name: _____

Date of Birth: _____ Age _____ Grade: _____

ALLERGIES: _____

Name of Medication: _____
Reason for Medication: _____
Form of Medication: (circle) Tablet Liquid Inhaler Injection Nebulizer
Dose (How many Mg or MI to be given) _____
Time to be Given at School or as needed _____
Effective for 2024/2025 School Year (Circle) YES or NO or Start and Stop Date: _____
Special Instructions: (refrigerate or with food, etc.) _____

Name of Medication: _____
Reason for Medication: _____
Form of Medication: (circle) Tablet Liquid Inhaler Injection Nebulizer
Dose (How many Mg or MI to be given) _____
Time to be Given at School or as needed _____
Effective for 2024/2025 School Year (Circle) YES or NO or Start and Stop Date: _____
Special Instructions: (refrigerate or with food, etc.) _____

Physician's Signature: _____ Date: _____

Physician's Name: _____

Physician's Address: _____

Physician's Phone Number: _____

To be completed by the Parent/Guardian:

I give permission for the above medications to be given by designated Holy Family School Staff.

Signature: _____ Date: _____

Relationship: _____ Phone: _____

*Includes prescription & over-the-counter medications, i.e. Tylenol, Benadryl, Claritin, ibuprofen, Neosporin, etc.
A Valid and current dated form must be submitted each school year.