

Frankenmuth High School  
*Medication Permission Form*

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Name of Medication(s) \_\_\_\_\_  
Date to begin \_\_\_\_\_ Date to end \_\_\_\_\_

**Prescribed by a Physician or authorized prescriber**  
*(Please provide **WRITTEN** instructions on the original container from the pharmacy)*

\_\_\_\_\_  
Name of Medication                      Time of Administration                      Dose                      Route

\_\_\_\_\_  
Physician's written instructions

\_\_\_\_\_  
Physician's signature (if required)

**Over the Counter** -- *please provide original container(s)*

\_\_\_\_\_  
Medication                      Time of Administration                      Dose                      Route

\_\_\_\_\_  
Special Instructions

\_\_\_\_\_  
Signature of Parent/Guardian                      Date

\*\*\*use the back of this sheet for any additional instructions or information.