



# Frankenmuth High School

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JoLynn Clark, Principal  
David Jaworski, Assistant Principal

Frankenmuth High School  
***Medication Permission Form***

Student Name: \_\_\_\_\_ Teacher: \_\_\_\_\_  
Grade: \_\_\_\_\_

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

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

Name of Medication	Time of Administration	Dose	Route <small>(oral/topical/nasal/inhalable/ophthalmic)</small>
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\_\_\_\_\_  
Physician's / Parent's additional instructions

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

Over the Counter  
*(Please provide the factory SEALED original container)*

Name of Medication	Time of Administration	Dose	Route <small>(oral/topical/nasal/inhalable/ophthalmic)</small>
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\_\_\_\_\_  
Special Instructions

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date