Livonia Franklin Marching Band
Controlled Medication Permission Form
(Only complete if student is taking Schedule II medications i.e., for ADHD/Pain)

Student Name: _____

Name of Medication: _____

Reason for Medication: _____

_____

Prescribed Dosage: _____

Time of Administration of Medication: _____

Possible Side Effects / Reactions to Medication: _____

_____

_____

All medication must be in the original container with patient's name, prescribing physician's name and directions for use.

Prescribing Physician

Physician Name: _____

Phone: _____

Street Address: _____

City: _____ ST: _____ Zip: _____

Parental Permission to Administer Medication

I hereby authorize the administering of my child's medication by an authorized chaperone, band director, or instructor exactly as per the directions prescribed by the above named physician.

Parent/Guardian Name: _____

Street Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____ Cell: _____

Signature: _____ Date: _____

Record of Administration must be kept on the reverse side of this form.

Record of Administration

Date	Time	Signature of Person Administering Medication