St. Paul's Lutheran School
Medication Consent Form

School Name/Address____

Name of Student______________________________ Grade________ D.O.B.______________________

Name of Parent____

Address____Home Phone______________________

Mom's cell phone______________________ Mom's Work phone_______________________________

Dad's cell phone_______________________ Dad's Work phone_______________________________

I request and authorize that the student identified above be able to receive medication as supervised by school personnel. I agree to supply the school with the properly labeled bottle of medicine. The label shall include the name of the child, the name of the medication, the dosage, frequency, name of physician (for prescription medications) and the name of the pharmacy (for prescription medications). I UNDERSTAND THAT ANY UNUSED MEDICATION CANNOT BE SENT HOME WITH MY CHILD.

* *

COMPLETE THIS SECTION FOR PRESCRIPTION MEDICATIONS

BEFORE PRESCRIPTION MEDICATION CAN BE RECEIVED AT SCHOOL BY THE STUDENT UNDER SUPERVISION, A SIGNED STATEMENT FROM THE PHYSICIAN INCLUDING DIAGNOSIS, NAME OF THE MEDICATION, DOSAGE, FREQUENCY AND POSSIBLE SIDE EFFECTS MUST BE ON FILE.

Name of Medication____

Dosage______________________Frequency/Time of Administration____________________________

Reason for Medication____

Condition/Circumstances requiring administration if medication is given on an as needed basis ________

____

____

Possible Side Effects to be Observed____

____

Name of Prescribing Physician_________________________ Phone___________________________

Physician Signature_____________________________________ Date__________________________

Parent/Guardian Signature_________________________________ Date__________________________

* *

COMPLETE THIS SECTION FOR NON-PRESCRIPTION MEDICATION

Name of Medication ____

Dosage_____________________Frequency/Time of Administration_____________________________

Conditions/Circumstances requiring administration if medication is given on an as needed basis________

____

____

Parent/Guardian Signature_______________________________ Date____________________________

CONSENT FOR ANY MEDICATIONS ON THIS FORM WILL BE IN EFFECT UNTIL THE END OF THE CURRENT SCHOOL YEAR.