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.

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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__________________________

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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________
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Parent/Guardian Signature________________________________ Date____________________________

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

June 2022

Asthma Inhaler Form Attached