Shepherd of the Hills Lutheran School

PERMISSION FOR THE ADMINISTRATION OF MEDICATION (Prescription)

Student ____ DOB __/___/___

Allergies __________________________

Name of Medication ____

Dose ____

Time ____

Route: □by mouth □inhaled □injection □other: _______________________

Reason to be administered: ____

Special instructions ____

____

I grant permission for the principal or principal's designee to assist in the administration of the above named medication for my child (named above). I certify that the prescribed medication is in its **original container** and that it is necessary, according to my physician's instructions, for this medication to be provided during the school day, including when my child is away from school property on official school business. I understand that this **medication will be given only according to the directions on the label as prescribed by the doctor**. Further, I agree to waive any claims of liability that may arise against any school personnel relative to the administration of medication to my child according to these directions. I further understand that, at the end of the school year, it will be my responsibility to pick-up any unused medication by the last day of the school year, otherwise the school will dispose of the medication.

___/___/____ ____________________________________ ________________________

Date Signature of Parent/Legal Guardian Parent/Legal Guardian phone #

I have determined that it is necessary for this medication to be provided during the school day for the above-named child. **(If you have determined the child needs to self-carry this medication, please also complete the section at the bottom of this form.)**

___/___/____ ____________________________________ ________________________

Date Signature of Physician Physician Phone #

DISPOSITION OF MEDICATION

____ I will pick up the unused/discontinued medication by the last day of the school year.

____ At the end of the school year contract, I do not wish to pick up the medication. The school has my permission to dispose of the medication.

___________________ ____

Date Signature of Parent/Legal Guardian