Shepherd of the Hills Lutheran School

PERMISSION FOR THE ADMINISTRATION OF MEDICATION (Over the Counter)

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 teacher 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**. 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.

____ 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 Parent/Legal Guardian phone #