

Trinity Lutheran School
Medication Permission

Prescription and *non-prescription* medications can only be given with physician and parent approval. The request must indicate the name of the medication, and the time and dose to be administered. Medication must be delivered by a responsible adult to the health office. ***All medications must be in the original bottle. Containers of loose pills will not be accepted.***

Student's Name: _____ **Grade** _____

TO BE COMPLETED AND SIGNED BY THE PHYSICIAN:

Medication #1 : _____

Dose, Route & Time: _____

Medication #2: _____

Dose, Route & Time: _____

This student has been instructed in the responsible use of the above named medication and can assume responsibility for self-administration on field trips under the supervision of an adult. YES _____ NO _____

Physician's Signature: _____ **Date:** _____

Physician's Stamp:

TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for my child to take the above named medication during school and field trips as prescribed by my child's physician.

Signature of Parent: _____ **Date** _____

Medication Permission Trinity Lutheran School

Student's Name _____ Grade _____

In order for medication to be taken in school, medication permission is required from the prescribing physician and the child's parent/guardian. This is for *prescription* as well as *non-prescription* medications. Medication must be delivered by a responsible **adult** to the health office. ***All medications must be in the original bottle properly labeled.*** A new form must be filled out for each change of dosage and new school year.

TO BE COMPLETED AND SIGNED BY THE PHYSICIAN:

Diagnosis _____

Name of Medication _____

Duration of regimen _____

Time and Dosage _____

Side effects to expect/report _____

This student has been instructed in the responsible use of the above named medication and can assume responsibility for self-administration on field trips. Yes _____ No _____

Physician's Signature: _____ Date _____

Physician's Stamp:

TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for my child to take the above named medication as prescribed by my child's physician.

Signature of Parent _____ Date _____