PARENT PERMISSION TO DISPENSE PRESCRIPTION OR OVER-THE-COUNTER DRUGS

Immanuel Lutheran School – Silo

Student:_____ Grade_____ Date of Birth___/____/____

Date form received by the school:_____

Name of medication:_____

Reason for medication:(OPTIONAL)_____

Form of medication/treatment:

Tablet/capsule Liquid Other_____

Instructions (Schedule and dose to be given at school):_____

_____

Beginning date: ____/____/____ End date: ____/____/____

Describe the circumstances which would trigger the administration/dispensing of this medication:

_____

_____

Are there special storage requirements? ___No ___Yes Describe: _____

_____

All medications must be in the original container with the student's name affixed to the outside of the bottle/container.

I understand that my child's homeroom teacher will be the primary person to dispense this medication, but that any school personnel may become involved for the same purpose.

I request that _____receive the above medication as indicated.

(Student's Name)

Date____/____/____Signature_____Relationship_____