Permission to Administer Medication in School Form

Student's Name:_____ Grade:_____

Classroom

Teacher:_____

Parent/Guardian:_____

_

Address: _____ Phone #:_____

Instructions for Administering Medication

Name of Medication	Dosage	Time of Day for Dosage	Date to Begin	Date to End

Purpose for Medication and Possible Side Effects

_____

_____

_____

_____

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Physician's Name:_____Phone #:_____

By signing this form I am giving permission for St. Stephen's Lutheran School to administer medication to my child as instructed on this form.

Parent/Guardian Signature:_____

Date:_____