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

_____

_____

_____

_____

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: _____

Raiders
ST. STEPHEN'S LUTHERAN SCHOOL
BEAVER DAM, WI