PERMISSION TO ADMINISTER MEDICATION FORM

Trinity Lutheran Church and School
613 Court Street
Saint Joseph, Michigan 49085
(269) 983-3056

Date Form Received by School Office: _____/_____/

I request that (name of child) ______________________________________ in Grade ________
receive the medication listed below according to the school medication administration policy, a copy of which I have received and read.

Date of Birth: _____/_____/______ Age:

Teacher:

Parent Signature:____ Date: ______/______/

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Please complete the following information unless the medication has an authorized pharmacy label on the container.

Name of medication:

Reason for medication:

Form of medication/treatment:

[ ] Tablet/Capsule [ ] Liquid [ ] Inhaler [ ] Injection [ ] Nebulizer

[ ] Other:

Instructions (Schedule, dose, and route to be given):

Start: [ ] Date form received Other dates:

Stop: [ ] End of school year Other date/duration:

[ ] For episodic/emergency events only

Restriction and/or important side effects: [ ] None expected

[ ] Yes, Please describe and state appropriate intervention:

Special Storage Requirements: [ ] None [ ] Refrigerate

[ ] Other:

Please indicate if you have added additional information:

[ ] On the back of form [ ] As an attachment

Physician’s Name:

Physician's Address:

Physician's Phone Number: (____)

8.15.07