St. John's Lutheran School
220 S. Lincoln Lombard, IL 60148
Phone: 630-932-3196 Fax: 630-282-0436

THIS FORM MUST BE COMPLETED and SIGNED BY A PHYSICIAN, BEFORE ANY MEDICATION CAN BE ADMINISTERED THROUGH THE SCHOOL OFFICE

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

2020-2021 School Year

Important Information

Medication should be brought to the school office in its original container, clearly marked with the student's name and the medication name and pertinent information**. This includes, inhalers, prescription medication and all over the counter meds (ie Tylenol, Advil, decongestants, allergy meds etc)**

I hereby grant permission for the authorized personnel of St. John's Lutheran School to administer the medication detailed on this form to my child.

_____ _____
Parent Signature Date

Student's Name_____ Birth Date _____

Phone Number _____

Teacher _____ Grade _____

PHYSICIAN OR PHYSICIAN'S REPRESENTATIVE MUST COMPLETE THIS SECTION & SIGN

Medication _____ Dosage_____ Reason_____

❒Liquid ❒Pill/Tablet/Caplet ❒Inhaler ❒Injection ❒Topical ❒Eye Drops

Time(s) to Administer _____ or _____ PRN (as needed) every _____ hours.

Additional Instructions_____

Possible side effects _____

- **The above named student may carry and self-administer his/her ❒inhaler or ❒ epi-pen.**

  I certify that s/he has been properly instructed in its use. Circle one: YES NO

Physician's Signature **Date** **Phone #**

Physician's Name (please print) _____