

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**  
2021-2022 School Year

Medication should be brought to the school office in its original container, clearly marked with the student's name, 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

Parent Emergency Phone Number \_\_\_\_\_

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Grade \_\_\_\_\_

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  EpiPen.

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) \_\_\_\_\_

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

Return this form to the school office with medication. Thank you.