St. Peter Lutheran School
Medication in School
Parent Request/Physician's Statement

Name of student_____Date:_____

Name of teacher_____Grade:_____

Medication may be dispensed to students at school if the following information is completed and the parent/guardian agrees to following terms and conditions.

Name of medication_____Dosage: _____

Time to be given: _____Length of time to be given: _____

Special instructions: _____

I understand and agree to the following:

1. A staff member will be assigned to give the medication to the student.
2. I, the parent/guardian, will bring the medication to the school personally and give it to a staff member.
3. The medication will be labeled by a pharmacist and in the pharmaceutical container. The label will state: Student's name, date name of medication, dosage, time to be given, special instructions, and physician's name.
4. St. Peter Lutheran Church and School and its staff are not responsible for the side effects of the medication. In return for the school's assistance in administering the medication to my child, I hereby waive on my behalf, and on behalf of my child, the right to maintain any legal action for damages against the school and its staff for any adverse effect that the medication may have on by child.

Parent/Guardian Signature: _____Date: _____

TO BE COMPLETED BY THE PHYSICIAN

Medication: _____Dosage: _____

Indication for Medication: _____Duration: _____

Special Instructions/Precaution: _____

Possible Side Effects: _____

Physician's Signature: _____

Telephone: _____