Our Savior Lutheran School
7910 East St. Joe Hwy.
Lansing, MI 48912
Phone 517-882-8665
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MEDICATION PERMISSION FORM

To be turned in with Student's Medication

School year _____

PARENT REQUEST FOR SCHOOL STAFF TO ADMINISTER MEDICATION

_____ _____
Student's Name *Date of birth*

_____ _____
Homeroom Teacher *Grade*

I hereby request school personnel to supervise the administration of the medication prescribed for my child, named above. It is understood that the school is administering medication to my child and/or supervising the administration thereof gratuitously and in reliance on my request (and, where applicable, in accordance with a physician's prescription) that the medication and dosages are safe. Accordingly, I assume all responsibility regarding this matter and hereby release the school, its personnel and governing administrative bodies from any and all liability as to injuries or ill effects of any kinds which may be caused thereby.

_____ _____
Signature of Parent/Guardian *Date*

OVER-THE-COUNTER MEDICATION

This form must be completed if you, as a parent, give Our Savior Lutheran School permission to give your child OTC medication while on school premises. Such medication may include acetaminophen, ibuprofen, or other over-the-counter medicine for pain, headaches, colds, allergies, etc. All medication must be stored in the school office and administered by an adult staff person.

IMPORTANT: Each parent is expected to provide the OTC medication for their child. The medication must be brought to school office with the manufacturer's original label on it and the ingredients listed. (*Note:* Do not send individual pills without the container to school.) The child's name should be written on the container and placed into a zippered plastic bag with the student's name clearly written on it in permanent marker.

PRESCRIPTION MEDICATION

Prescription medications that are necessary to maintain the health and comfort of the child in school and must be given during the school hours shall be administered after this form is signed and on file. The form must clearly indicate any precautions which need to be taken. This form must be renewed at the beginning of each school year if the need for the medication continues.

IMPORTANT: Each prescription medication shall be displayed in original package or appropriately labeled container including Prescription Number, Licensed Prescribers' Name, Pharmacy Name and Number. Please put medicine in a zippered plastic bag with the student's name written on it in permanent marker. Fill in all the information below for the prescribed medication and return this form with the medication.

Name of Medication: _____

Dosage: _____

Date Medication Begins: _____ Date Medication Ends: _____

Administration / Other Directions: _____

_____

Possible Side Effects and Treatment: _____

_____

_____