St. Peter's Lutheran School

Authorization for Administration of Medication by School Personnel

8701 Elk Grove-Florin Road, Elk Grove, CA 95624
Phone: (916) 689-3050 Fax: (916) 689-3462

2011 - 2012

(Please note: This form must be completed each school year or more frequently as necessary. Please refer to page 15 in the Parent/Student Handbook for more information.)

Student: _____ Age: _____ Date of Birth: _____

School: *St. Peter's Lutheran School* _____ Grade: _____

PHYSICIAN INSTRUCTIONS: - *Please note*: Medical personnel are **not** available on the school campus. Whenever possible, please prescribe medication that can be given outside of the school day. If medication must be administered during school hours, please complete the information below:

Medication	*Dosage*	*Route of Administration*	*Approximate time of day*

Diagnosis or indication for medication: _____

Length of time to be taken: _____

Precautions, if any: _____

1. For **emergency medication**, is the student capable of self-administering the necessary treatment/medication? Yes: ___ No: ____
2. Will the student need to carry this medication on his/her person? Yes: ___ No: ____
3. Will the student need to self-administer this medication? Yes: ___ No: ____

Please note obvious side effects to this particular medication: _____
_____

_____ _____
Signature of Physician (for prescription meds) *Address*

_____ _____ _____
Print/type Physician's Name *Phone* *Date*

_____ _____ _____
Parent/Guardian's Signature (for nonprescription meds) *Phone* *Date*

Parent Request

I/we the undersigned, who is/are the parent(s) of _____ request that medicine be administered to my child by a member of the school staff, in accordance with the instructions outlined above and signed by our physician. In agreeing to have the school administer our child's medication, I voluntarily agree to release, discharge, and hold harmless St. Peter's Lutheran School and its officers, agents, and employees for any and all claims of liability arising out of their negligence or any other act of omission which causes our child's illness, injury, death, and damages of any nature in any way connected with the administration of our child's medication.

We understand that the major responsibility for a child taking medication rests with the child and his/her parents, and that we are required to personally bring the medication to the school office.

_____ _____ _____
Parent/Guardian's Signature *Date* *Home Phone*