

Walther Lutheran High School

900 Chicago Avenue
Melrose Park, IL 60160
708.344.0404

Permission to Administer Medication at School 2009/2010 School Year

(Please Print)

Important Information:

1. Medication is to be brought to school in a pharmaceutical container, or, for Over The Counter (OTC) medications, the original container, clearly marked with the student's name, the medication name, and pertinent information.
2. In the event of any change in prescription or dosage, new permission forms must be submitted to the Student Service Office.
3. Medication and permission forms will be kept in the Student Service Office. Medication will be kept in a locked drawer in the Student Service Office.
4. Any medication, including OTC medication such as Tylenol, must have a Physician's signature. Throat lozenges do not need a physician's signature.
5. Students will be given the container and will need to self medicate. In extreme situations where a student appears to be incapable of administering the medication independently, Walther staff may assist a student in the administration of medication.
6. The date, time and name of the medication will be recorded.
7. Upon request, parents will be notified whenever a PRN (as needed) medication is given to the student.
8. Medication not picked up at the end of the school year will be disposed of.
9. A new Permission to Administer Medication form must be completed each school year.

The principal or his designee of Walther Lutheran High School is herewith granted permission to oversee the administration of the below mentioned medication in the Student Service Office as required. The responsibility for the proper administration of the medication is still mine as parent and I do not, or will not, hold the school or any staff member thereof responsible for any complication which might arise from the medication.

Parent/Guardian Signature

Date

Student Name _____

Birth Date _____

Medication _____

Dose _____

Time given _____ AM _____ PM _____ PRN (as needed) every _____ hours

Possible side effects _____

Special Instructions _____

Medication _____

Dose _____

Time given _____ AM _____ PM _____ PRN (as needed) every _____ hours

Possible side effects _____

Special Instructions _____

Physician's Signature

Phone Number

Date

**THIS FORM MUST BE RETURNED TO THE STUDENT SERVICE OFFICE BEFORE ANY
MEDICATION WILL BE ADMINISTERED.**

