

ST. JOHN'S LUTHERAN SCHOOL
WEST BEND, WISCONSIN 53095

MEDICATION AUTHORIZATION

I hereby request and authorize the personnel of St. John's Lutheran School, West Bend, WI, to administer the medication listed below to my child:

_____.

Medication Name Reason for Medication Dosage Time to be Taken Begin/End Date

This authorization is good until: _____

With this signed agreement, I/We absolve the designated person(s) administering the medication, St. John's School, and any and all members of the boards of any responsibility and liability for any reaction, complication, etc. which may occur to the above-named child during the time of receiving the medication indicated on this form.

Signature of Parent: _____ Date: _____

I understand that:

1. All medication, prescription and non-prescription, must be provided by the parent in person in its original container with a legible label.
2. Label must contain:
 - A. Name of student (first & last)
 - B. Name of drug
 - C. Dosage to be given
 - D. Date to begin administering at school
 - E. Date to end administering at school
 - F. Name and phone number of the pharmacy
 - G. Name of the prescribing physician
3. All medication must be stored in the school office except for inhalers for asthma.
4. School office personnel will administer the medication to the student.
5. Parents must submit written permission authorizing the school to administer medication to their child
6. Asthma inhalers must be registered through the school office.
7. This information is confidential and will only be used for purposes related to the administration of medication.

Signature of School Administrator _____.