PARENT PERMISSION TO DISPENSE PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS

St. Johns Lutheran School - Wykoff, MN

Student: _____ Grade: _____ Date of Birth

____/____/____

Date form received by St. Johns: ____/____/____

Name of medication:

_____

Reason for medication:

(OPTIONAL)_____

Form of medication/treatment:

Tablet/Capsule Liquid Other: _____

Instructions: (Schedule & dose to be given at school)

_____

_____

_____

Beginning date ____/____/____ Ending date ____/____/____

Describe the circumstances which would require the administration of this medication:

_____

_____

Are there special storage requirements? ____No ____Yes - Describe:

_____

All medications must be in the original container with the student's name affixed to the outside of the bottle/container.

I understand that my child's homeroom teacher or the St. Johns Lutheran School Administrative Assistant will be the primary person to dispense this medication. Any school personnel may dispense the above mentioned medication in their absence.

The undersigned parent for himself, his agents, successors, assigns, or representatives, hereby releases, indemnifies, holds harmless, and forever discharges St. Johns Lutheran School and its agents, successors, assigns or employees from all claims, demands, actions, causes of action or suits of whatsoever kind or nature known or unknown arising from dispensing medications as per the terms of this agreement.

2022-2023

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I request that _____ receive the above medication as indicated. (Student's Name)

Date _ _ _ _ / _ _ _ _ / ____Signature_____Relationship_____