

**PARENT PERMISSION TO DISPENSE PRESCRIPTION OR
OVER-THE-COUNTER DRUGS
St. Johns Lutheran School, Wykoff, MN**

Student: _____ Grade _____ Date of Birth ___/___/___

Date form received by the school: _____

Name of medication: _____

Reason for medication:(OPTIONAL) _____

Form of medication/treatment:

Tablet/capsule Liquid Other _____

Instructions (Schedule and dose to be given at school): _____

Beginning date: ___/___/___ End date: ___/___/___

Describe the circumstances which would trigger the administration/dispensing 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 Mrs. Schultz will be the primary person to dispense this medication. Any school personnel may dispense medications 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.

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

Date ___/___/___ Signature _____ Relationship _____