

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 Mrs. Voigt 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.

I request that _____ receive the above medication as indicated.

(Student's Name)

Date ____/____/____ **Signature** _____ **Relationship** _____