Medication Administration Request Form

Name of Student: _____ Grade: _____

(Permission applies only to dates specified below)

Start Date: _____ End Date: _____

Name of Medication: _____

Time to Administer: _____
(Medications routinely given at the child's lunchtime. Please write Teacher a note to send child to the office.)

Amount to Administer: _____

For what condition are we administering this medication? _____

I hereby request Grace Lutheran School personnel to supervise the administration of the medication prescribed for my child named above. It is understood that the school is administering medication to my child and / or supervising administration thereof gratuitously and in reliance on my request (and the statement of the physician that the prescribed medication and dosages are safe). Accordingly, I assume all responsibility regarding this matter and hereby release the school, its personnel and governing administrative bodies from any and all liability as to injuries or ill effects of any kind which may be caused by school personnel failure to remind students to take prescribed medication and to monitor its dosage.

_____/_____
Parent/guardian Signature **Date**

(This portion for office staff only)

Drug:	Dosage:	Date:	Time:	Authorized Signature: