Prescription Medication PERMISSION FORM

TO: School Personnel at

St. Peter's Lutheran School
719 Fifth Street
Columbus, IN 47201
(812) 372-5266 (phone)
(812) 372-7556 (fax)

RE: Administration of Medications to: _____
(student name)

To be completed by the physician or authorized prescriber:

This notice is to inform you that the above named student, enrolled in your school, is currently under my medical care. As a part of that care, this student must receive the following medication for the medical indication listed, at the dosage, route, and interval prescribed below.

Indicated Medical Diagnosis: _____

Medication: _____

Dosage, Interval, & Route: _____

Length of Therapy: _____

Additional Information: _____

I request and authorize you to administer this medication in accordance with the above instructions. These instructions remain in force until: _____. Problems concerning administration of this medication can be referred to at:

_____ _____
Address Physician's Signature

_____ _____
Telephone Number Date

To be completed by the parent/guardian:

We, as parents of _____, request, authorize and give written permission to you to administer the medication prescribed above in accordance with the instructions provided. We agree to notify you immediately of any change in circumstances concerning administration of this medication.'

_____ _____
Address Parent/Guardian Signature

_____ _____
Telephone Number Date