St. John Lutheran School and Little Lamb Preschool
Laying Foundations for the Future

MEDICATION ADMINISTRATION FORM

OVER THE COUNTER MEDICATION

Student's Name _____ Grade _____

(TO BE COMPLETED BY PHYSICIAN)

This child _____ is under my medical care for _____ and medication is needed during the school day for the purpose of _____.

Name of Drug	Dosage	Frequency	Time to be Given at School	Duration	Side Effects

Signature of Physician _____ Date _____

Printed Name of Physician _____ Phone Number_____

Address _____
(Street) (City) (State) (Zip)

(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

I/We, _____ give permission for my/our child to receive the above over the counter medication(s) as directed by the physician. The medication will be sent to school in a container appropriately labeled by the manufacturer. I/We will notify the school in writing if the medication is discontinued. Also, I/we will obtain a written doctor's order if the medication dosage is changed. The medication will be brought to the school office.

Parent Signature _____ Date _____

Parent Signature _____ Date _____

Please return to
St. John Lutheran School
509 S. Mattis Ave.
Champaign, IL 61821
Phone: 217-359-1714
Fax: 217-359-1714