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

# MEDICATION ADMINISTRATION FORM

## PRESCRIPTION MEDICATION

Student's Name _____ Grade _____

**(TO BE COMPLETED BY PHYSICIAN)**

This child _____ is under my medical care for _____ and medication is required 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 prescribed medication(s) as directed by the physician. The medication will be sent to school in a container appropriately labeled by the pharmacy. 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**