

**St. Paul Lutheran School
1415 Tenth Avenue
Rochelle, IL 61068
815-562-6323**

SCHOOL MEDICATION PERMISSION FORM

Our school health policy states that no over-the-counter or prescription medications are to be given to students unless the school nurse has a written order from the doctor and a written request from the parent. All medication sent to the school must be in the original prescription bottle, clearly labeled with the name of the student, the doctor, the medication, the dosage and the time to be given. Our school health policy also requests that medications not be transported on the school bus.

Below are sections for the parent and the doctor to complete:

STUDENT _____ BIRTHDATE _____
ADDRESS _____ PHONE _____
GRADE _____ TEACHER _____

PARENT REQUEST SECTION

As the parent or legal guardian of the above named student, I hereby request that school personnel supervise the self-administration of the prescription as designated below.

Parent Signature Date

.....
PHYSICIAN REQUEST SECTION

Name of medication _____
Dosage _____ Frequency _____
Time to be given at school _____
Diagnosis requiring medication _____
*Length of time this prescription is to be in effect _____
Expected side effects, if any _____

I hereby request that the school nurse or her authorized personnel supervise the self-administration of the prescription noted above, as it is medically necessary for doses to be given during school hours.

Physician's signature

Address Phone

Date

*No longer than one school year. A new request slip is needed for changes in this prescription.