St. Paul Lutheran School
Request for Self-Administration of Medication

_____ _____
NAME OF STUDENT BIRTHDATE

_____ _____
ADDRESS PHONE NUMBER

To:

Principal, St. Paul Lutheran School

The above named pupil has _____
NAME OF DISEASE, SYNDROME, OR CONDITION

I am requesting that the above named student take the following medication during school hours.

_____ _____
NAME OF MEDICATION TYPE OF MEDICATION
(TABLET, LIQUID, CAPSULE, INHALANT, ETC.)

_____ _____
DOSAGE TIME(S) TO BE GIVEN

_____
POSSIBLE SIDE EFFECTS

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently with school staff supervision.

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____ _____ _____
PHONE NUMBER OF PHYSICIAN SIGNATURE OF PHYSICIAN DATE

_____ _____ _____
ADDRESS OF PHYSICIAN PRINTED NAME OF PHYSICIAN DATE

I request that the school staff supervise _____ in
NAME OF STUDENT
the self-administration of medication. I understand that medications that can be scheduled for non-school hours should be given at home. I understand that the medication must be brought to the school in the original pharmacy container with the original label.

_____ _____
SIGNATURE OF PARENT DATE