St. Paul's Lutheran School

1626 E. Broadway Ave.
Enid, Oklahoma 73701
(580) 234-6646 Fax: (580) 234-6692

SCHOOL MEDICATION REQUEST
School Year: 2022-2023

Reset Form

IT IS THE POLICY OF ST. PAUL'S LUTHERAN SCHOOL BOARD OF EDUCATION THAT THE STAFF MAY NOT ADMINISTER ANY PRESCRIBED OR OVER-THE-COUNTER MEDICATIONS UNLESS THE FOLLOWING INFORMATION IS FILLED OUT BY PARENT/GUARDIAN AND THE MEDICATION IS PROVIDED

Student's Name:			**Grade:**	-- Select --	
Date of Birth:		**Weight:**		**Age:**	
Address:					
	Street Address		*City*	*State*	*Zip code*

**** All over the counter medications must be labeled and provided by the parent. ****

My child may receive the following over the counter medication as directed:

**** Prescription Only: Please accompany with instructions from the doctor. ****

Date medication begins:		**Date medication Ends:**	
Name of medication:			
Dosage:			
Possible side effects:			
Doctor's Name:		**Doctor's Phone:**	

Physician signature: _____ **Date:** _____
Agree to the above information, paste signature here or After printing sign here return to office. MM / DD / YYYY

I hereby request school personnel to supervise the administration of the medication prescribed for my child, named above. It is understood that the school is administering medication to my child and/or supervising the administration thereof gratuitously and in reliance on my request (and the statement of the physician that the prescribed medication and dosages are safe). Accordingly, I assume all responsibility regarding this matter and hereby release the school, its personnel and governing administrative bodies from any and all liability as to injuries or ill effects of any kinds which may be caused thereby, including those ill effects caused by school personnel failure to remind students to take the prescribed medication and to monitor its dosage.

Parent / Guardian signature: _____ **Date:** _____
Agree to the above information, paste signature here or After printing sign here return to office. MM / DD / YYYY

For those students who <u>self-administer</u> an inhaler or epi pen, complete the next page.
SELF-ADMINISTRATION

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SELF-ADMINISTRATION

has asthma and is capable of, and has been instructed in the proper use of self-administration of an inhaler.

Date medication begins:		**Date medication Ends:**	
Name of medication:			
Dosage:			
Possible side effects:			
Doctor's Name:		**Doctor's Phone:**	

Physician signature: _____ **Date:** _____
Agree to the above information, paste signature here or After printing sign here return to office. MM / DD / YYYY

St. Paul's Lutheran School shall incur no liability as a result of any injury arising from self-administration by a student.

Parent / Guardian signature: _____ **Date:** _____
Agree to the above information, paste signature here or After printing sign here return to office. MM / DD / YYYY

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has an Epi Pen and is capable of, and has been instructed in the proper use of self-administration of an Epi Pen.

Date medication begins:		**Date medication Ends:**	
Name of medication:			
Dosage:			
Possible side effects:			
Doctor's Name:		**Doctor's Phone:**	

Physician signature: _____ **Date:** _____
Agree to the above information, paste signature here or After printing sign here return to office. MM / DD / YYYY

St. Paul's Lutheran School shall incur no liability as a result of any injury arising from self-administration by a student.

Parent / Guardian signature: _____ **Date:** _____
Agree to the above information, paste signature here or After printing sign here return to office. MM / DD / YYYY