PRESCRIPTION MEDICATION REQUEST

Reset Form

St. Paul's Lutheran Church & School

1626 E Broadway Ave.

Enid, Oklahoma 73701

school@stpaulsenid.com

P: 580.234.6646 F: 580.234.6692

Date:

It is the policy of St. Paul's Lutheran Church & School (SPLCS) board of education that the staff may not administer any prescribed medications unless the following information is filled out and signed by the student's primary care physician and a parent/guardian. Please email or fax completed form to St. Paul's Lutheran Church and School at **(580) 234 – 6692**

Student Information (Required for both pages)

First Name: Middle: Last:

Address: City:

State: Zip: Grade: Age:

Use this side is for prescription medication only : please accompany with instructions from the doctor
Use other side for prescription inhaler or epi pen : self-administering medication

Physician's Prescription Information

Medication Name:

Dosage: Date to begin: Date to end:

Physician's Instructions:

Possible side effects:

Physicians Name: Physician's Phone:

Physicians Signature

Date:

Parent's Permission for prescription medication

I hereby request SPLCS school personnel to supervise the administering 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 administering 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, it's personnel and governing administrative bodies from any and all liabilities as to injuries or ill effects of any kinds which may be caused thereby, including those ill effects caused by school personnel failing to remind students to take the prescribed medication and or monitor its dosage.

Parent/Guardian Signature

Date:

PRESCRIPTION MEDICATION REQUEST

Self-Administering Inhaler

Physician's Prescription Information

Medication Name:

Dosage: Date to begin: Date to end:

Physician's Instructions:

Possible side effects:

Physicians Name: Physician's Phone:

Physicians Signature

Date:

Self- Administering Epi Pen

Physician's Prescription Information

Medication Name:

Dosage: Date to begin: Date to end:

Physician's Instructions:

Possible side effects:

Physicians Name: Physician's Phone:

Physicians Signature

Date:

Parent's Permission for self-administering medication

I HEREBY REQUEST SPLCS SCHOOL PERSONNEL TO SUPERVISE THE ADMINISTERING OF THE MEDICATION PRESCRIBED FOR MY CHILD, NAMED ABOVE. IT IS UNDERSTOOD THAT THE SCHOOL SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM SELF-ADMINISTERING BY A STUDENT.

Parent/Guardian Signature

Date: