ILLINOIS LUTHERAN SCHOOLS, INC

1610 MAIN ST. CRETE, IL 60417

PERMISSION TO ADMINISTER MEDICATION

When no other plan is feasible, school personnel will cooperate in giving of medication at the request of the child's parent or physician.

By signing this form, the parent authorizes the school to administer medication only according to the guidelines as described below. Therefore it is necessary that the parent gives a full and clear description of the medication procedure. Without clear directions, school personnel will not administer medication in any form. School personnel will not administer medication based only upon the medication's label.

Name of Child_____

Name of Medication_____

Prescribing Physician's Name_____

Prescribing Physician's Telephone_____

Dosage_____

Frequency_____

Duration_____

Purpose of medication (ailment)_____

Additional Instructions_____

_____

_____ **School personnel are hereby given authority to dispense non-aspirin pain reliever to my child upon his or her request.**

I hereby authorize school personnel to administer medication as outlined above.

Parent's signature_____ **Date**_____