PRESCRIPTION MEDICATION FORM
and OVER-THE-COUNTER MEDICATION

ONE PER STUDENT

Student:	Grade:	Parent Phone:
Medication 1:	Dosage:	Time of Day:
Medication 2:	Dosage:	Time of Day:
Medication 3:	Dosage:	Time of Day:

REQUIRED FOR PRESCRIPTION ONLY		
Physician/Office Signature	Physician Name:	Physician Phone:

I authorize St. John's Lutheran School to dispense the medication to my child in the dosage amount and time of day as indicated above.

Special Instructions:

NOTE: All unused medicines not picked up by a parent/guardian at the end of the school year will be disposed of permanently.

_____ _____

Authorizing Signature Date

Relationship to Student: ☐ Mother ☐ Father ☐ Grandparent ☐ Guardian

Updated: August 3, 2017