St. Peter Lutheran School

Authorization and Permission for Administration of Over the Counter Medication

Student's name: ___________________________________ DOB: ______________________

Grade: ______________________ Homeroom Teacher: _____________________________

Date medication begins: __________________Final date of medication: __________________

Please indicate which medications may be administered to your child by marking "x" on the line before the name of the medication.

____ Acetaminophen (like Tylenol)
____ Ibuprofen (like Advil or Motrin)
____ Antacid (like Tums)
____ Anti itch cream or gel (like topical Benadryl or Calamine lotion)
____ Antihistamine (like Benadryl (liquid, chews, strips)
____ Antibiotic ointment (like Neosporin or Bacitracin)
____ Cough drops
____ Aloe gel (for sunburn)
____ Sterile eye wash
____ Hydrogen peroxide (to clean wounds)

Administration Instructions: All medications will be administered according to the package insert unless otherwise specified. ____

Physician's signature: __________________________________Date: _____________________

Physician's phone#: _______________________Emergency phone#: ____________________

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of an emergency, I hereby authorize St. Peter Lutheran School and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child, lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against St. Peter Lutheran School, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify St. Peter Lutheran School, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries or resulting from the administration or attempts at administration of said medication.

Parent's signature: ____Date: ________________

Parent's phone #'s: Home________________________Mobile______________________________

Business______________________________

Parent's address: ____

06/08

Dear Parents/Guardians:

In order to serve you and enable your child to stay in school even if he/she is experiencing a minor ailment, we need to know your desires regarding medical treatment of your child. The nurse's office has a very limited choice of medications available for mild physical discomforts or pain. A permission form for the administration of these medications is attached to this letter. **Please note that a physician's signature is required** for any medications to be given to your child while they are at school. This form will be kept on file through this school year and will then need to be renewed each year.

Should your child require any other medication on a daily or as needed basis as per physician's orders, contact my office for proper procedures.

If you have any questions, please feel free to contact my office.

God's Blessings on your summer!

Martina Lang, RN
St. Peter School Nurse
224-387-3847

Over…