

# SAINT LUCAS EVANGELICAL LUTHERAN SCHOOL

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## Administration of Medication Form

### PARENT REQUEST:

I request the school secretary/staff members to assist my child, \_\_\_\_\_, in taking the medication prescribed by Dr. \_\_\_\_\_ for the period of (dates) \_\_\_\_\_ to \_\_\_\_\_. The medication will be delivered directly to the school secretary, principal, or designated staff member.

I, the parent or guardian, agree, by signing this request and “hold harmless” statement, that I shall not hold liable any member of the school staff who assists my child in taking said medication.

Parent/Guardian’s Signature \_\_\_\_\_ Date \_\_\_\_\_

### PHYSICIAN REQUEST:

Please administer the following prescribed medication to:

Child’s Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Medication: \_\_\_\_\_

Dose: \_\_\_\_\_

Directions: \_\_\_\_\_

Physician’s Signature: \_\_\_\_\_ Date \_\_\_\_\_