Christ-St. John's Lutheran School
500 Park St.
West Salem, WI 54669

PERMISSION TO ADMINISTER ORAL MEDICATION IN SCHOOL

Student's Name___________________________________ Grade_____________

Classroom Teacher ____

Parent's Name ____

Address ____________________________________Phone # _______________

Instructions for administering medication at school.

Name of Medication	Dosage	Time to be Administered	Begin (date)	End (date)

Please indicate purpose of Medication listed above and possible side effects.

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Physician's Name ____________________________ Phone ________________

Date Contacted ____

Parent's Signature ______________________________ Date _______________

Authorizing administration of medications indicated above.

Bring this form and medication to school office. Medications will be kept there.
Medications will be dispensed by the office manager whenever possible.