



Administration of Medication

Lafayette Lutheran School

This completed form shall be on file for each student requiring medication

CHILD'S FULL NAME _____ GRADE _____ AGE _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ WORK/CELL _____

PARENT'S RELEASE FROM LIABILITY

For and in consideration of allowing said child to attend school in spite of his specific health problems, we hereby release, relieve and discharge Lafayette Lutheran School and any of their agents or employees from any and all liability for any injury or damage to the child arising out of, or related to, or resulting from the said child taking medication during school hours.

I have read, understood and agree to the school's regulations concerning giving medication at school.

Signature of parent or guardian

Date

The following information must be completed by your child's physician:

1. Diagnosis: _____

2. Medication Dosage & Route: _____

3. Time to be Given: _____

4. Reason for Medication: _____

5. Duration of Medication Order: _____

Signature of Physician

Date

Print Name of Physician

Physician's Phone Number