LUTHERAN HIGH SCHOOL

PARENT/GUARDIAN MEDICATION REQUEST FORM
(for prescribed medication and over the counter drugs)
(Please type or print information)

Full Name of Child to receive Medication _____

Name of Drug and Dosage _____

Hour(s) medication to be given _____ Number of Days _____

Physician prescribing medication _____ Phone _____

Reason for medication _____

I, hereby give permission for school personel to give medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician if there is a question. Parents agree to notify the school when the drug is to be discontinued and/or the dosage or time is to be changed. If the medication is resumed, a new request form/order must be received. I agree to hold the Sheboygan Lutheran High School, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

_____

Signature of Parent/Legal Guardian Date

_____

Address

Adopted: August 19, 1999
Sheboygan Area Lutheran High School
3323 University Drive
Sheboygan WI 53081