GOOD SHEPHERD LUTHERAN SCHOOL

13OO Beltline Road ~ Collinsville, IL. 62234 ~ (618) 344-3153 ~ Fax: (618) 344-3156

Parent Authorization / Request for Self-Administration of Medication

STUDENT: _____ Birth date: _____ Today's date:_____

Student's Address: _____ Phone #: _____

COMPLETED BY PARENT ****** Additional medications may be listed on the reverse******

MEDICATION: _____

DOSAGE: _____
(Route) (Approx. time to be given at school)

Possible Side / Adverse Effects: _____

Reason for medication: _____ Allergies: _____

MEDICATION: _____

DOSAGE: _____
(Route) (Approx. time to be given at school)

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MEDICATION: _____

DOSAGE: _____
(Route) (Approx. time to be given at school)

Possible Side / Adverse Effects: _____

Reason for medication: _____ Allergies: _____

(Asthma inhalers and Epi-Pens): I certify that the above named student has been instructed in the proper use and self-administration of the above named medication.)

I am requesting that the above named student self-administer this medication during school hours. This student understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

I authorize school personnel, on my behalf, to supervise the self-administration of the medication named above by my child, at school as prescribed by the physician listed above. I waive any claims, damages, causes of action or injuries incurred, I might have against Good Shepherd, its employees and agents arising out of the administration or attempts to administration of said medication. I have read and understand the school's medication policy on the reverse side.

_____ _____
PRINTED PARENT'S NAME PARENT'S SIGNATURE

_____ _____
PARENT'S ADDRESS HOME / BUSINESS / CELL PHONE NUMBERS