Immanuel Lutheran School ~ 620 Bush Street ~ Lakefield, Minnesota 56150
Phone: 507-662-5860 ~ Fax: 507-662-5860

Over-the-Counter Medication Administration Authorization Form

Student: _____ Date of Birth: _____

Grade: _____ School Year: _____ Student Weight: _____

Parent/Guardian: _____

Daytime Phone Number: _____

Parent/Guardian must complete this form for over-the-counter medications to be administered in school. Medications must be provided in original manufacturer container. Medications will only be administered to the student according to the label directions unless written directions from the physician are provided.

I give permission for the following medication(s) to be administered by the appropriately designated personnel during school hours:

Medication	Reason for Use
Medication	Reason for Use
Medication	Reason for Use

Additional information if necessary:

This authorization will be valid for the length of the current school year unless otherwise stated by the parent/guardian

Parent Signature: _____ Date: _____

Immanuel Lutheran School ~ 620 Bush Street ~ Lakefield, Minnesota 56150
Phone: 507-662-5860 ~ Fax: 507-662-5860

Over-the-Counter Medication Administration Record

Student: _____ Date of Birth: _____

_____ _____
Medication Dose Medication Dose

_____ _____
Medication Dose Medication Dose

	Medication	Date	Time	Reason	Signature
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					

Immanuel Lutheran School ~ 620 Bush Street ~ Lakefield, Minnesota 56150
Phone: 507-662-5860 ~ Fax: 507-662-5860