Trinity Lutheran School
1165 Westmore Meyers Rd.   Lombard, IL 60148
Phone: 630-627-5601   Email: secretary@trinitylombard.org

THIS FORM MUST BE COMPLETED and SIGNED BY A PHYSICIAN, BEFORE ANY MEDICATION CAN BE ADMINISTERED THROUGH THE SCHOOL OFFICE

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

2024-2025 School Year

Important Information

1. Medication should be brought to the school in its original container, clearly marked with the child's name and the medication name and pertinent information**. THIS INCLUDES, INHALERS, PRESCRIPTION MEDICATION AND ALL OVER THE COUNTER MEDS (Advil, Tylenol, Midol, Decongestants, Allergy etc)**
2. If dosing amount, timing or any changes occur during the school year, it is the parent's responsibility to communicate that and provide a new completed Permission to Administer form to the office immediately.
3. Medication and permission forms will be kept in the office. (Teachers will take student's mediations on field trips).

I hereby grant permission for the authorized personnel of Trinity Lutheran School to administer the medication detailed on this form to my child.

____   ______________________
Parent Signature   Date

Student's Name_________________________________ Birth Date ______________

Phone Number ______________________

Teacher ___________________________   Grade ______________

PHYSICIAN OR PHYSICIAN' S REPRESENTATIVE MUST COMPLETE THIS SECTION & SIGN

Medication ____________________ Dosage__________ Reason________________

❒Liquid ❒Pill/Tablet/Caplet ❒Inhaler ❒Injection ❒Topical ❒Eye Drops

Time(s) to Administer ________ or _____ PRN (as needed) every _______ hours.

Additional Instructions____

Possible side effects ____

- **The above named student may carry and self-administer his/her ❒inhaler or ❒ epi-pen.**

  I certify that s/he has been properly instructed in its use. Circle one: YES NO

____
Physician's Signature   Date   Phone #

Physician's Name (please print) _____________________________________

Rev. 3/6/24