

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**  
2026-2027 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 medications 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 \_\_\_\_\_

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) \_\_\_\_\_

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