MEDICATION AGREEMENT 2017-2018

Bethlehem Lutheran School Grade:_____ Teacher: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request and give my permission to Bethlehem Lutheran School, Early Learning Center & Childwatch to administer medication to my child. I understand that it is my responsibility to provide the medication in the original pharmacy labeled container. I also understand that the person administering the medication may not alter or change any medications from their original form (cut or half pills, etc.).
Any prescription changes will require an additional signed and completed Medication Agreement.

Name of Student_____ DOB_____

Parent's Name_____ Phone_____

Medication_____ Dosage_____

Continuous From_____to_____

_____ _____
Signature of Parent or Guardian Date

TO BE COMPLETED BY PHYSICIAN

Patient's Name_____

Medication_____ Route_____

Purpose_____ Times to be given_____

Dosage_____ Possible side effects_____

Continuous From_____to_____

FAX No._____

Name of Physician_____

Phone No._____

_____ _____
Signature of Physician Date

Only employees who are trained and delegated may give medications. The person giving the medication must put their initials and time they gave medication in the appropriate box.

Delegated by: Jodi Garmatz RN, BSN, MMS

INITIALS	PERSON DISPENSING MEDICATION	DELEGATED TITLE	DATE
_____	_____	_____	_____
_____	_____	_____	_____

This document is effective for the 2017-2018 school year through summer 2018.