MEDICATION AGREEMENT 2018-2019

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______________

Route___________________________ Times to be Given _______________________

____ ____________________

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______________

Name of Physician__________________________

Phone Number____________________ FAX Number_____________________

____ ____________________________

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: Wendy Moore RN, MSN, CPEN | Nurse Consultant

INITIALS	PERSON DISPENSING MEDICATION	TITLE	DATE
________	________________________________	_______	__________
________	________________________________	_______	__________

This document is effective for the 2018-2019 school year through summer 2019.

SUPPLEMENTAL MEDICATION LOG

Student Name: ______________________ Medication: ______________________
Student Number: ______________________ Date of Birth: ______________________
Dose #1 Start time: ______________________ Dose # 2 Start time: ______________________

Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Month:			Year:		
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Month:			Year:		
Week 2	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Month:			Year:		
Week 2	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Month:			Year:		
Week 2	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Month:			Year:		
Week 3	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Month:			Year:		
Week 3	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Month:			Year:		
Week 3	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Month:			Year:		
Week 4	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Month:			Year:		
Week 4	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Month:			Year:		
Week 4	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Month:			Year:		
Week 5	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Signature

ANC ____________ Date ________

Month:			Year:		
Week 5	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Signature

ANC ____________ Date ________

Month:			Year:		
Week 5	Mon	Tue	Wed	Thu	Fri
Date					
Dose #1					
Dose#2					

Signature

ANC ____________ Date ________