MEDICATION AGREEMENT 2019 - 2020

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_________________________

Route___________________________ Times to be Given___________________________

Continuous From________to________

____ ___________________

Signature of Parent or Guardian Date

TO BE COMPLETED BY PHYSICIAN

Patient's Name____

Medication________________________ Dosage_________________________________

Route________________________ Times to be Given____________________________

Purpose______________________ Possible side effects__________________________

Continuous From_________to________ Phone Number:_______________

Name of Physician________________________ 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 2019-2020 school year through summer 2020.