

St. Peter Lutheran School
N2740 French Rd.
Appleton, WI 54913

PERMISSION TO ADMINISTER ORAL MEDICATION IN SCHOOL TO STUDENTS IN GRADES 5K – 8.
ANY MEDICATION THROUGHOUT THE SCHOOL YEAR REQUIRES THIS FORM.

Student's Name: _____ Grade: _____

Classroom Teacher: _____

Parent's Name: _____

Address: _____ Phone: _____

Instructions for administering medication at school.

Name of Medication	Dosage	Time to be Administered	Begin (date)	End (date)

Please indicate purpose of Medication listed above and possible side effects.

Physician's Name: _____ Phone: _____

Date Contacted: _____

Parent's Signature: _____ Date: _____

Authorizing administration of medications indicated above.

Bring this form and medication in its original container directly to the **school office**. Medications will be kept in a secure location. Medications will be dispensed by the school staff.

St. Peter Lutheran School
N2740 French Rd.
Appleton, WI 54913

**PERMISSION TO ADMINISTER ORAL MEDICATION IN SCHOOL TO STUDENTS IN 3K & 4K.
ANY MEDICATION THROUGHOUT THE SCHOOL YEAR REQUIRES THIS FORM.**

Student's Name: _____ Grade: _____

Classroom Teacher: _____

Parent's Name: _____

Address: _____ Phone: _____

Instructions for administering medication at school.

Name of Medication	Dosage	Time to be Administered	Begin (date)	End (date)

Please indicate purpose of Medication listed above and possible side effects.

Physician's Name: _____ Phone: _____

Date Contacted: _____

Parent's Signature: _____ Date: _____

Authorizing administration of medications indicated above.
Bring this form and medication in its original container directly to our **Early Childhood Director**.
Medications will be kept in a secure location. Medications will be dispensed by the school staff.