



**GUIDELINES FOR DISPENSING MEDICATION TO STUDENTS**  
**TRINITY LUTHERAN SCHOOL**  
**2018-2019**

If a student requires medication during school hours, the distribution of the medications will be supervised by school staff under the following guidelines required by state law:

1. Parents/guardians must sign the appropriate administration forms.
2. All medication must be supplied in the original container and have the student's name clearly marked on it.
3. All prescription medication must be accompanied by written instructions from a physician and consent from parent/guardian. The container must be identified with the following information: student's name, name of medication, doctor's name and phone number, pharmacy and phone number.

**All medication (prescription and over-the-counter) is placed in a locked cabinet in the school office.**

In order to administer any prescribed medication OR over-the-counter medication to a student, there must be a signed authorization form. Students can NEVER give other students any type of medicine.

When use of medication has ceased, or is no longer needed by the student, it is the parent/guardian's responsibility to retrieve unused medications from the school. Any unused medication will be disposed of by the school after the last day of school for that school year.

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**Medication Administration Consent:**

This consent form will remain effective through June 1, 2019. A new form must be filled out if any changes occur.

Child's Name (Last name first): \_\_\_\_\_

Name of Medication #1: \_\_\_\_\_

Dose: \_\_\_\_\_ Time(s) to be given: \_\_\_\_\_

How it is given: \_\_\_\_\_

Can this medication be self-administered by the child? \_\_\_\_\_ YES \_\_\_\_\_ NO

Side effect and any special instructions: \_\_\_\_\_

Name of Medication #2: \_\_\_\_\_

Dose: \_\_\_\_\_ Time(s) to be given: \_\_\_\_\_

How it is given: \_\_\_\_\_

Can this medication be self-administered by the child? \_\_\_\_\_ YES \_\_\_\_\_ NO

Side effect and any special instructions: \_\_\_\_\_

Parent Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

(Physician signature not required for over the counter medications)