

**Fox Valley Lutheran High School
Parent/Guardian Medication Consent Form**

Full name of student to be medicated _____
 Name of drug and dosage _____
 Time medication to be given _____ Number of days _____
 Prescribing Physician (prescriptions only) _____ Phone _____
 Reason for Medication _____

I hereby give permission to the employee designated by the Principal, or designee, to give the above medication(s) to my child according to the directions stated above and further authorize them to contact my child's physician. I agree to hold Fox Valley Lutheran and its employees who are acting within the scope of their duties harmless from any and all claims arising from the administration of this medication.

I agree to notify the school in writing when any change in the above order is necessary.

I understand that a completed and signed Physician's Order for Medication Administration form is required to be filed with the District before a prescription drug can be administered.

Signature of Parent/Guardian _____ Date _____
 Address _____

Physician Order for Medication Administration (Prescriptions Only)

To: Fox Valley Lutheran High School
 RE: Student Name _____ Address _____
 Phone _____ School _____ Grade _____

Please administer the following medication(s) to the student named above according to the following orders:

Prescription Medications:

Medicine	Route	Dose	Frequency	Duration	Further Instruction	Contact Physician If:

I agree to retain the power to direct, supervise, decide about, inspect and oversee the administration of this medication(s). You may contact me at anytime should a question arise.

Physician's Signature _____ Date _____
 Address _____ Phone _____