# Holy Trinity Lutheran School

*"Where the education of the heart is the heart of education"*

## Medication Release Form

**Parent request and Physician's Order**

**Absolutely no medications (including non-prescription medication) will be administered at Holy Trinity without this form or a comparable form completed and on file.**

## To be completed by parent:

Child's Name _____ Age ____ Teacher_____ Grade _____

I request that my child be administered the medication as indicated in the physician's order below. I understand that non-medical personnel may at times administer this medication. I understand that it is my responsibility to provide the medication for my child.

_____ _____

Parent/Guardian Signature Date

## To be completed by Physician:

The child indicated above must have the medication listed below administered during school hours.

_____ _____ _____

Name of Medication Dosage Hour to be given

Side effects to watch for:_____

_____

For 5th – 7th grade exercise induced asthma Medication may be administered by: Self _____ School personnel _____

_____ _____

Method of administration Duration of order

_____ _____ _____

Telephone Number Physician's Name (please print) Physician's Signature

## The above information may be faxed to 843-7466; ATTN: School Office

**Health Room:**

**Verify medication name, dosage, name on medication, dosage on medication, log medication in book. If form is complete, file in appropriate medication file; if not complete file in back of medication book until completed.**

_____

**Signature of person accepting form and medication in health room**

Revised 1/07

553 Ashmoor Avenue • Bowling Green, KY 42101
Phone 270-843-1001 • Fax 270-843-7466 • Website www.htlsbg.com

# NON-PRESCRIPTON MEDICATIONS:

## To be completed by parent:

Child's Name _____ Age ____ Teacher_____ Grade _____

I request that my child be administered the non-prescription medication I have provided. I understand that non-medical personnel may at times administer this medication.

_____ _____
Parent/Guardian Signature Date

_____ _____ _____
Name of Medication Dosage Hour to be given

Duration (daily, one-time, as needed) _____

Does this medication need to be returned home with child? Yes____ No _____ If yes, when? _____

Side effects, if any, to watch for:_____

_____

**Health Room:**
**Verify medication name and dosage, log medication in book. If form is complete, file in appropriate medication file; if not complete file in back of medication book until completed.**

_____
**Signature of person accepting form and medication in health room**

**If necessary, returned home _____ (date)**

**Person to whom medication was given to take home. _____**