**CHRIST LUTHERAN CHURCH & SCHOOL**
**(2026– 2027 SCHOOL YEAR)**

PARENTAL CONSENT FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

## SECTION 1 - STUDENT INFORMATION

**Student Name**: _____ **DOB:** _____

**Teacher:** _____ **Grade:** _____

**Parent Name:** _____

**Daytime Phone #:** _____ **Alternate #:** _____

**List student's allergies:** _____

**List other medication student is taking:** _____

## SECTION 2 – MEDICATION INFORMATION

**1. Name of Medicine:** _____

**2. Dose:** _____ **Time(s) to be given:** _____

**3. Route:** ☐**Orally** ☐**Inhaled** ☐**Injected** ☐**Other:** _____

**4. Start Date:** _____ **End Date:** _____

**If asthmatic, please list signs and/or symptoms most often present when medication is needed:**
☐ Breathing difficulty: wheezing and/or chest tightness
☐ General: apprehension/panic, blue lips, pale, dizziness
☐ Other: _____

**5. Possible Side Effects:** _____

_____

**6. Action to be Taken In Case of Side Effects:** _____

_____

## SECTION 3 – PARENTAL CONSENT

I request that my child be assisted in taking the above prescribed medication at school by authorized persons, and will comply with the school's policies and procedures. If this request is granted, I agree to hold the school and its employees harmless in providing this service to my child. I hereby give consent to the school to communicate with my physician and to counsel with school personnel regarding the possible effects of the drug on my child's physical, intellectual, and social behavior, as well as possible behavioral signs and symptoms of adverse side effects.

**Date:** _____ **Parent/guardian Signature:** _____

**Printed Name:** _____ **Relationship:** _____

**Please return this form to:** Christ Lutheran School Office, (310) 831-0848 x. 1100 or fax (310) 831-0090