# MEDICATION DISTRIBUTION EXEMPTION FORM

**MEDICATION:**
All medications given to a student during school hours must be administered by the school office. To request administration of any medication, (e.g. Tylenol, cough drops, over the counter medications, and prescription medications) please fill out this form and return it to the school office. No medications will be given to students who do not have this form on file.

**EXEMPTION:**
Trinity Lutheran Church & School understands that some medications need to be administered in case of emergency and therefore need to be with the student at all times. These exemptions to this policy must be requested by the physician and approved by the administration.

All medications must be in the original container with all of the labels intact. The Student's name and date must also be placed on each container. Prescription medications need to have the physician's name and "directions for use" clearly visible on the container.

Student's Name: _____ Date of Birth: _____

| MEDICATION | DATE BEGINS | DATE ENDS | TIME TAKEN | DOSAGE |
|---|---|---|---|---|
| | | | | |
| | | | | |

Physician's Authorization: _____ Date: _____

Trinity Lutheran Church & School, its employees and its volunteers are not responsible for reminding your child to take their medications or any adverse effects your child might have pertaining to this medication. Trinity Lutheran Church & School reserves the right to withdraw this authorization at any time without cause.

I assume all responsibility for this medication and its administration. I release the school from any liability from adverse effects due to the medication or administration of the medication.

Parent Signature: _____ Date: _____

# SPECIAL CARE PLAN FOR A CHILD WITH ALLERGY

CHILD'S NAME: _____ DATE OF BIRTH: _____

FACILITY NAME: _____

Parent(s)/Guardian(s) Name: _____

Emergency Phone Numbers: Mother _____ Father: _____

Primary Health Provider Name: _____ Phone: _____

Specialist's Name (if any): _____ Phone: _____

Description of Allergy: _____

_____

Describe what signs/or symptom look like: _____

_____

Describe know triggers: _____

_____

Describe treatment: _____

_____

Possible side effects: _____

Program modification: i.e. no peanut products allowed _____

_____

When to call parent/health provider regarding symptoms or failure to respond to treatment:

_____

When to consider what condition requires urgent care or reassessment: _____

_____

Physician's Name: _____

Physician's Signature: _____ Date: _____

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