AUTHORIZATION FOR MEDICATION

To Parent/Guardian: See handbook for complete information. All medications including daily maintenance medication and asthma medication must be kept in the school office. All medication should be brought to school in approved containers by an adult.

To be completed by physician yearly for prescription medication

To: School Personnel of St. Paul's Lutheran School

Re: Prescribed medication for ______________________________

(Diagnosis)

This named student ______________________ is currently under my care. As part of that care, this he/she must receive the following medication(s):

____

____

I request and authorize you to administer this medication in accordance with the above instructions. These instructions remain in effect for the current school year or until ___________ if not for the entire school year or unless you are otherwise notified by me. Questions concerning these prescriptions can be referred to me at my office.

Physician's signature	Street Address
Physician's printed name	City/Town
Date	Office phone number

To be completed by parent/guardian for nonprescription medication

Medication Name (eg Tylenol)	Dispensing instructions (be specific) (1 325 mg strength, 1 tablet per day)

I, the parent/guardian of ______________________ request, authorize and give written permission to the principal or other adult staff member to administer the medication(s) listed above according to instructions provided. I agree to notify the school of any change in circumstances concerning the administration of this medication. Any other medications besides 325 mg adult strength Tylenol will be provided from home.

Date	Street Address
Parent/Guardian Signature	City/Town
Parent/Guardian Signature	Home, cell and work telephone number

Complete record of administering medication on reverse side. 6/15

Record of administering medication/prescription

Date	Time	Medication/reason	Initials