ST. PAUL'S
LUTHERAN SCHOOL

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

_____ Physician's printed name

_____ Date

_____ Street Address

_____ City/Town

_____ Office phone number

To be completed by parent/guardian for nonprescription medication

Medication Name (example "Tylenol")	Dispensing instructions (be specific) (Example "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

_____ Parent/Guardian Signature

_____ Parent/Guardian Signature

_____ Street Address

_____ City/Town

_____ Home, cell and work telephone number

Complete record of administering medication on reverse side.6/22

Record of administering medication/prescription

Date	Time	Medication/reason	Initials