Grace Lutheran School
Authorization to Administer
Prescription Medication

Student_____ Birth Date_____

Grade_____ School Year_____

Parent/Guardian 1:_____ Parent/Guardian 2:_____

Daytime Phone (_____)_____ Daytime Phone (_____)_____

Cell (_____)_____ Cell (_____)_____

Authorization expires at the end of the school year or following the summer school session.

Parent/Guardian Medication Consent:
I give my permission to school personnel to give this medication to my child according to the directions stated below. I also give permission for an exchange of information between school district personnel and the health care provider, if necessary, regarding this medication. I agree to notify the school in writing at the withdrawal of this request or when a change in this medication occurs. I agree to hold the school district and personnel harmless in any claims arising from the administration of this medication at school.

I understand that it is my responsibility to:

- Transport the medication to school in a labeled container
- Replace the supply of medication when needed
- Pick up medication or direct staff to discard remaining medication upon discontinuation or at the end of the school year

Parent/Guardian Signature_____ Date_____

Health Care Provider's Order for Medication to be Given at School

Medical Condition:	
Name of Medication:	
Dosage Of Medication:	_____mg / cc / tsp _____drops / puffs Form: ☐ Tablet / Capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other_____
Route:	☐Oral ☐Eyes ☐Ear ☐Nose ☐Topical ☐Other_____
Administration Time	☐ Daily at:_____ ☐ As Needed- Describe frequency & symptoms for which medication should be given _____ ☐ May be repeated in _____ minutes/hours
Possible Side Effects:	
For inhaled asthma medication ONLY:	☐ In my professional opinion, this student should be allowed to carry and use this mediation by him/herself. ☐ In my professional opinion, this student SHOULD NOT carry this medication by him/herself.

Health Care Provider's Name (Please print)_____Phone(_____)_____

Health Care Providers Signature_____Date_____