MEDICATION AUTHORIZATION FORM
Immanuel Lutheran School
Washington, Missouri

Students needing medication to be given during school hours must have a medication authorization on file in the school office. *These forms must be completed and signed by the physician and parent and returned to the school office before any medication may be given. All medication, including over-the-counter medications, must have an authorization form completed.*

Parents must supply the medication in a container with the original label, appropriately labeled for administration during school hours. Medicine to be given at school is to remain at school for the period of time it is to be given. Please have your pharmacist label two containers for prescription medications, one for school and one for home.

I hereby request school personnel to supervise the administration of the medication for my child, named below. It is understood that the school is administering medication to my child and/or supervising the administration thereof gratuitously and in reliance on my request and the accompanying physician request. Accordingly I assume all responsibility regarding this matter and hereby release the school, its personnel and governing administrative bodies from any and all liability as to injuries or ill effects of any kinds which may be caused thereby. This includes those ill effects caused by school personnel failure to remind students to take the prescribed medication and to monitor its dosage.

Student Name_____Grade_____D.O.B._____

Medication _____

Dosage_____ Time_____ Total Daily Dosage_____

Starting date for medication_____ Discontinue medication on_____

Reason for taking medication _____

Possible side effects _____

Student allergies to past medications _____

Physician's name: _____Physician Office Number_____

_____
Physician Signature Date

Printed or Typed Name of Physician_____

_____
Parent Signature Date

Printed or Typed Name of Parent_____

AN ADULT MUST BRING ALL MEDICATION TO THE SCHOOL OFFICE. DO NOT SEND IT WITH THE STUDENT

PLEASE TURN OVER

Request for Child to Self-Administer Medication

I have trained the child named above and consider the child to be capable of self-administering an inhaled medication, an epi-pen, or insulin. *Only a rescue inhaled medication for asthma or an epi-pen for severe allergic reactions may be carried by the student.*

_____

Physician Signature Date

Printed or Typed Name of Physician_____

In accordance with the physician's request, we want our child to self-administer the above named medication. I realize there are additional responsibilities in doing so and assume responsibility for those liabilities

_____

Parent Signature Date

Printed or Typed Name of Parent/Guardian:_____