Trinity Lutheran School
Medication Authorization

Student's Name: _____Grade: ____ Teacher: _____

Parent's Address: _____ Parent's Phone: _____

City/Zip: _____

Physician: _____ Physician's Phone: _____

Physician's Address (include City) _____

Name of Medication: _____

Dosage: _____

Time of Administration: _____

Anticipated Duration **Start Date**: _____

Stop Date: _____

Purpose of Medication: _____

Possible Side Effects: _____

_____

Student may carry INHALER: **Student may carry EPIPEN:**

_____No _____Yes **_____No _____Yes**

Students that carry inhalers, EpiPens and cough drops may not be supervised during administration.

I hereby request that my child be administered his/her prescribed medication at school by the school personnel authorized by the principal. I understand that the medication will be administered exactly as per the instructions of my above named physician. I will notify the school of changes or discontinuation of this medication(s). I further agree that you may contact the physician who prescribed the medication and I hereby authorize him to release to school office any and all information concerning my child's condition and/or treatment.

Parent/Guardian Signature: _____ Date: _____