SALEM LUTHERAN SCHOOL
AUTHORIZATION FOR ADMINISTRATION OF MEDICINE

This authorization is for permission to administer prescription, scheduled and /or over the counter medications to my child. The medication is listed below and is to be given as instructed.

Student's Name ____

Date of Birth ___________________________ Grade Level______________________

It is necessary for the following medication to be administered during school hours in the form and dosage specified below, in order to maintain this child's physical health and provide maximum school performance.

Name of Medication ____

This medication is to be given for the following reason: (e.g. Headache, Strep Throat, Stomach ache)
____

How long is this medication to be given? (e.g. one week, two days, as needed) ______________________

Dosage (e.g. one teaspoon, one tablet) _________________________________

Please indicate how medication is to be given:
__By mouth __Inhalant __Topical (e.g. ointment) __ Other ____________

Time medication is to be administered: _________________________________

I hereby grant permission for the School Nurse and or a delegated representative at the school to administer the medication named above to my child. The "over the counter" medication and /or the prescription medication will be in its original container. The over the counter medication will be labeled with my child's name. The prescribed medication will be labeled by a U.S. pharmacy with the child's name, name of medication and clear directions for administration. Medications must be brought to the school nurse or front office. Medications may not be transported by students or kept in their locker or backpacks.

I give permission for exchange of verbal and written communication between the physician and school nurse regarding my child's medical needs. Salem Lutheran School and its staff shall be immune from civil liability for damages or injuries resulting from the administration of medication to my child.

______________ __________________________ ________________________
Parent/Guardian Signature Date

Home Phone Number: ____________________
Cell phone number: ____________________
Work Phone Number: ____________________

***Physician Signature:** ________________________ **Date**___________________
Phone Number: ________________________

***Physician's signature needed if medication is to be administered for more then 15 consecutive days, and for treatment of chronic conditions requiring long-term medication administrations as in ADD or asthma**.