HOLY TRINITY
LUTHERAN SCHOOL

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

One Medication per Form

Authorization and request for the administration of medication at school for prescription and/or non-prescription medication.

Student _____Birthdate _____Grade_____ School Year_____
Date received_____

1. Reason for medication_____
2. Name of medication_____
3. Dosage_____
4. Time to be administered_____
5. Duration (week, month, indefinite, etc.)_____
6. Side Effects: None Expected_____ Specify_____
7. Form of medication/treatment: Tablet____ Liquid____ Inhaler____ Injection____ Nebulizer____ Other_____
8. Special storage requirements: None _____ Refrigerate _____ Other_____

TO BE COMPLETED BY THE PARENT/GUARDIAN: I hereby request and give my permission for Holy Trinity Lutheran School to administer the medication prescribed on this form. Prescription medication must have the pharmacy label attached and must match the written prescriber order. "Over the counter medication" must be in the original container. All Medication must be brought to school by an adult. Substances not approved by the FDA will not be stored nor administered by school personnel. I further understand that I will be responsible for picking up any remaining medication at the end of the school year; medication will NOT be sent home with students. Any medication remaining after the school year has ended will be discarded utilizing proper procedure.

I understand and acknowledge the above statement.

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Parent Signature/Date