SALEM
LUTHERAN SCHOOL

AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION

STUDENT NAME: _____ **Birthdate:** _____ **Grade:** _____

STUDENT ALLERGIES: _____

NAME OF PARENT: _____

HOME #: _____ **WORK #:** _____ **CELL #:** _____

I am requesting and hereby give permission to school personnel to give the following medication during school hours to my child named below in order to maintain my child's physical health and support school performance. To my knowledge, my child has no allergy to this medication.

NAME OF MEDICATION: _____

DESCRIPTION OF CONDITION | REASON FOR MEDICATION: _____

_____

_____

DOSAGE: _____

TIME TO BE GIVEN: _____

IMPORTANT INFORMATION FOR PARENTS | GUARDIANS

The medication listed above must be supplied by the parent | guardian and must be in the original manufacturer's container with an original label containing dosage instructions. All Over The Counter medications must be FDA approved and only the age-appropriate dosage as indicated on the container will be given. Salem Lutheran School and its staff shall be immune from civil liability for damages or injuries resulting from administration of medication to my child.

I hereby acknowledge that I have read and accept the Salem Lutheran School medication policy and will update the School Nurse in writing with any changes to my child's allergies or health information. An up to date medication policy, containing the latest information can be found in the Family Handbook.

PARENT | GUARDIAN SIGNATURE: _____ **DATE:** _____

Please return this form to the school nurse and/or bring with medication.