SALEM
LUTHERAN SCHOOL

AUTHORIZATION FOR PRESCRIPTION MEDICATION

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

STUDENT ALLERGIES: _____

NAME OF PARENT: _____

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

I request and hereby give permission to Salem School personnel to give the prescription medication to my child named below as requested by a physician. I give permission for exchange of verbal and written communication between the physician and School Nurse regarding my child's medical needs. In the event a home dose is missed, parent may notify the school nurse for the missing dose to be administered.

The prescribed medication will be labeled by a U.S. Pharmacy with the child's name, name of medication and clear directions for administration. 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:** _____

PHYSICIAN'S STATEMENT

In order that this school child remain in optimum health and to maintin maximum school performance, it is necessary that the following medication be given during school hours.

Description of Condition | Reason for Medication: _____

Prescribed Medication & Strength: _____

Dosage: _____ **Route:** _____ **Time(s):** _____

Medication is taken at home as follows: _____

_____

Dosage: _____ **Time(s):** _____

Possible Adverse Reaction(s): _____

Special Instructions: _____

_____

Prescribing Physician's Signature: _____ **Date:** _____

Physician's Printed Name: _____ **Office #:** _____ **Fax #:** _____

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

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