ST. PETER LUTHERAN SCHOOL

Prescription/Non-Prescription Medication Authorization Form

Student Name: _____ Birthdate: _____

Teacher: _____ Grade: _____

Date: _____

To be completed by parent/guardian:

Medication (in original container)	Dose	Time To Be Given	Form/Route*	Possible Side Effects	Adverse Reactions (Report to Parent)

*Routes: oral(pill/capsule/chewable, liquid), inhaled (inhaler, nebulizer), topical skin application, topical (eye drop, ointment), topical ear drop, injection, other

List symptoms/conditions under which medications ordered as needed (p.r.n.) are to be given:

_____

_____

If (p.r.n.), MINIMUM amount of time between doses: _____

Reason for medication (optional): Medication #1: _____

Medication #2: _____

Special Instructions: _____

Start Date: _____ Stop Date: _____

I request and give permission for (name of child) _____ to receive the above medication(s) at school according to standard school policy and for the physician's staff and school personnel to share relevant information regarding my child's medication needs.

Parent's Name: _____ Phone #: _____

Parent/Guardian Signature: _____ Date: _____