Our Savior Lutheran School
2019-2020 MEDICATION AUTHORIZATION

Authorization for medical interventions to be administered by school personnel:

To be completed by the parent or physician:

Child's Name: _____ Birth Date: _____ Grade: _____

Allergies: _____

Name of Medication	Dose	Form (tablet, liquid, etc.)	Time(s) to be administered

Reason for medication: _____

Special instructions: _____

_____

Start: ☐ date form received other start date: _____

Stop: ☐ end of school year other stop date: _____

Restrictions and/or possible side effects: _____

Special storage requirements: _____

Physician's Name: _____ Phone #.: _____

& Address: _____

I hereby request that Our Savior Lutheran School provide the above ordered medication to my child, _____. I will not hold the school personnel responsible for complications related to this intervention. Any change in the procedure/medication will be accompanied by an updated statement.

_____ _____

Signature of Parent/Guardian Date

FOR OFFICE USE ONLY
Date form received: _____