Our Savior Lutheran School
2021-2022 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: __________________________