

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: _____