MESSIAH
LUTHERAN SCHOOL

MEDICATION AUTHORIZATION FORM

I hereby authorize the staff at Messiah Lutheran School to administer the medication described below to my child : _____ _____

Child's Name **D.O.B**

I understand that school personnel will administer only the medication described below. If the prescription is changed, a new form for parent consent and a new physician's order must be completed before the school staff can administer medication.

Name of Medication: _____

Dosage: _____**Time to be given**: _____

Reason for taking medication:_____

Authorization Effective from _____ to _____
Date Date

Possible side effects: _____

Medication Requirements: Prescription medicine must be in the original container and labeled with the child's name, instructions, and physician's name. All over the counter medicine must be in the original container and should be labeled with the child's name and dosage. Medication cannot be for "general use", parent must give specific times and dates in order for it to be administered.

Physician Signature _____ **Date** _____

Parent Signature _____ **Date** _____

Request for Child to Self-Administer Medication

I have trained the child named above and consider the child to be capable of self-administering an inhaled medication, an epi-pen, or insulin. Only a rescue inhaled medication for asthma or an epi-pen for severe allergic reactions may be carried by the student.

Physician Signature _____ **Date** _____

In accordance with the physician's request, we want our child to self- administer the above named medication. I realize there are additional responsibilities in doing so and assume responsibility for those liabilities.

Parent Signature _____ **Date** _____