Our Savior Lutheran School
2024-2025 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: ___________________________