Authorization for Medication

Student Name _____ Birth Date _____

Grade _____ Homeroom/Teacher _____

Physician's Authorization

In order to keep this child in optimum health and to maintain maximum school performance,
it is necessary that medication be given during school hours.

Medication _____

Reason for medication _____

Circle form of medication: Tablet / Capsule / Inhaler / Liquid / Ointment / Allergy Injection / Other _____

Dosage (amount to be given) _____

Start Date _____ Stop Date _____

Time to be given: _____A.M. _____ P.M. Relationship to meals _____

Side Effects _____

Contraindications for Administration _____

If an emergency situation occurs during school hours, or if a reaction occurs, school officials are to:

1. Contact Parent: Home _____ Work _____ Mobile _____

2. Contact Physician's Office: Phone _____ FAX _____

3. For _____ reaction, take child to ER at _____

Physician's Name (print) _____

Physician's Signature _____ Date _____

Parental/Guardian Authorization

I hereby give permission for my child, named above, to receive medication during school hours. I release Lighthouse Christian School, their agents and their employees from any and all liability whatsoever that may result from my child taking this medication. I am responsible for providing the medication in a properly labeled pharmacy container with identifying information (child's name, medication, dosage, time to be given.)

Print Parent's Name _____

Parent's Signature _____ Date _____

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