MEDICATION AUTHORIZATION FORM

Student Name _____ Date of Birth _____

Grade _____

This Section to be Completed by Your Child's Physician

Please give the medication prescribed by me as follows:

Medication: _____ Daily: _____ PRN: _____

Dosage in School: _____ Route: _____ Time: _____ Frequency: _____

Describe Indications/Diagnosis: _____ Side Effects: _____

Other Instructions: _____

Inhalers Only: May self-carry and/or self-administer: Yes: _____ No: _____

Physician Signature *Physician Name (print)* *Date*

This Section to be Completed by Parent/Guardian

I am aware that special permission is required for students to take medication during school hours. I give permission to St. Luke's School to have my child_____ take the above medication during school hours.

Medication will be supplied by me in the original prescription labeled container with my child's name, name of medication, dosage and time to be given. I understand that if it is necessary for my child to take medication on a field trip away from school, I will provide one school day's supply of the medication in the original prescription bottle for my child to self-carry and self - administer.

Parent/Guardian Signature *Date* *Best Contact Phone Number*