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.

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