Authorization to Administer Prescriptive Medication

Physician's Statement

I have prescribed the medication indicated below for ____
and do hereby authorize Emmaus Lutheran School to administer the medication as indicated:

Medication:____

Dosage: (amount and time)____

Dates of
Administration:____
____

Comments:____
____
____
____
____
____

____________________________________ ____________________________
Physician's Signature **Date**

Parent's authorization

I do hereby authorize Emmaus Lutheran School to administer to my child,_______________________, as prescribed by the physician above. I understand that I will be responsible for supplying this medication to the school. This medication will be kept only in the school office and only dispensed from the school office. Records will be kept by the school secretary when each and every dose of the medication is given.

____________________________________ ____________________________
Parent's Signature **Date**

Note: The Physician's statement and parent's authorization are only valid until the prescription is used up. In the case of prolonged medication, the validation may be until the end of the school year.

Medications must be provided in original containers. This is to prevent dosing or other errors for the students protection. Thank you.

TO BE PLACED IN THE STUDENT'S FILE AFTER COMPLETION. KEEP WITH MEDICATION FOR DURATION OF DOSING.