Authorized/Parental Consent for Administering Medication

(Use a separate form for each medication)

Student's Name _____ Grade _____
Allergies _____

Name of Medication _____
Condition Prescribed for _____

Parental Consent

I am the parent or guardian of _____. I give my permission for him/her to take the following prescribed medication while in Trinity Lutheran Church. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medications. I hereby release Trinity Lutheran School and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the above licensed prescriber.

_____ _____ _____
Parent/Guardian Daytime Phone Date

Medication Authorization

(For Use by licensed Prescriber **ONLY**)

Relevant Diagnosis _____ Medication _____
Dates medication must be administered at school:

____ Short Term (List dates to be given _____)

____ Everyday at school ____ Episodic/ Emergency Events ONLY

Dosage (Amount) _____ Form _____ Time(s) of Day _____

A. Serious reactions can occur if the medication is not given as prescribed: ____ YES ____ NO
If yes, describe:

B. Serious reactions/adverse side effects from this medication may occur: ____ YES ____ NO
If yes, describe:

Action/Treatment for reactions: _____
Report to you: _____ YES _____ NO (Drug information sheet may be attached)

Special Handling Instructions: ____ Refrigeration _____ Keep out of sunlight ____ Other _____

Asthmatic/Diabetic ONLY

This student is both capable and responsible for self-administering this medication:
___ NO ___ YES-Supervised ___ YES-Unsupervised
This student may carry this medication: ____NO ___ YES

Licensed Prescriber's Name _____
Telephone Number _____ Emergency Number _____
Licensed Prescriber's Signature _____ Date _____