

Medication Authorization Form

Name of Student: _____

Medication: _____

Dosage: _____ (Amount and times during the day)

Special Instructions *(including any special storage requirements and noting any side effect(s) of which the school should be aware)*

Reason for the medication: _____

Date: _____ Name of Physician: _____

Signature of Physician: _____

PARENTAL CONSENT AND WAIVER

I hereby give my permission for my child _____ in the ____ grade at Zion Lutheran School to take the above prescribed medication at school.

Notice: No prescription medication may be used or possessed at school unless the school receives this completed form. All medicine brought into the school must be kept by the school secretary in the ZLS office and must be in the original container, appropriately labeled by the pharmacy or physician.

WAIVER OF LIABILITY

I understand that Zion Lutheran School will administer only the prescribed medication mentioned above. I hereby waive any, and all claims against the school, and agree to hold the school harmless from any and all liability, which may arise in connection with my child's use of the medication.

Parent or Guardian's Signature _____ Date: _____