Authorization to Administer PRESCRIPTIVE MEDICATION

School Year_____

Physician's Statement

I have prescribed the medication indicated below for _____
and do hereby authorize Zion 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 Zion Lutheran School to administer medication 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 or Guardian's Signature **Date**

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