Authorization to Administer PRESCRIPTION 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 office staff when each and every dose of the medication is given.

Complete only if applicable - I give permission for my child, _____, to carry and self-administer the medication as prescribed by the physician above to treat asthma, diabetes or seizures.

I further acknowledge and agree that, when the prescribed medication is administered, attempted to be administered, or self-administered, I waive any claims I might have against Zion Lutheran School, its employees and agents arriving out of the administration of said medication. I agree to hold harmless and indemnify Zion Lutheran School, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

_____ _____

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.