Calvary Lutheran High School

Medication Authorization Form 2010-2011
During School Hours

The following section is to be completed by PARENT or GUARDIAN only:

Student's Name: _____ _____ _____ _____
Last First Gender Birthdate

Physician's Name: _____ _____ _____
Address Phone

The following medications are available in the school office. To allow **one** dose of these over-the-counter medications to be administered to your child, please place a check mark next to the medication then sign and date.

Tylenol: _____ Ibuprofen: _____ Aleve: _____

Parent/Guardian Signature: _____ Date: _____

I request my child be given the described medication by authorized school personnel.

Name of Medication: _____ _____ _____
Form (liquid, tablet, etc. Dosage

_____ _____
Diagnosis for which medication is given: administer how frequently?

What time should medication be administered? _____

Length of time medication is to be given (one day, week, etc.) _____

If medication is given "as needed," please describe symptoms: _____

List significant side effects, if any (drowsy, hyper, agitated, thirsty, etc.): _____

_____

Information or comments which authorized school personnel should be made are of such as Allergic Reactions to Medicine, Food, or Environmental Factors:

_____

It is your responsibility to notify school officials of any changes in your student's information including, but not limited to, physician, medications, insurance, etc. We must have your permission to contact the pharmacy where you child's prescription
was filled, in case we have questions regarding the prescription.

Parent/Guardian Signature: _____ Date: _____