

# Martin Luther School

Small School.  Smart Choice.

## PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

**A. To be completed by the parent or guardian:**

I request that my child receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.

Parent/Guardian's Name (Please Print): \_\_\_\_\_

Signature (Parent or Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: Cell : \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

**B. To be completed by physician:**

I request that my patient, as listed below, receive the following medication:

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN

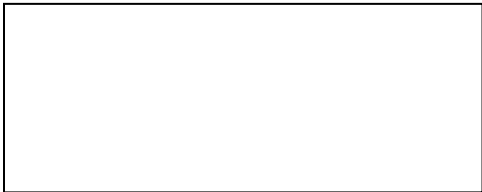
Duration of Treatment: \_\_\_\_\_

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_

Physician's Name (Please Print): \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_



Please Stamp

\*Please return this form with the medication to the Attendance Office\*