Martin Luther School

Small School. Smart Choice.

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

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