Medication Administration Authorization Form
2014-2015

(Please write legibly)

Date: _____

Student Name _____
Last First MI

Birth date _____ Age _____ Weight _____ Grade/Teacher _____

Allergies _____

As the parent/guardian of the student named above, I request that the Principal, or the Principal's Designee, of Holy Trinity Lutheran School administer the prescription medication described below to my child.

↓ Medication Name #1	↓ Medication Name #2
_____ Dosage	_____ Dosage
_____ Time	_____ Time
_____ Reason for Medication	_____ Reason for Medication
_____ Side Effects	_____ Side Effects
_____	_____

Special Instructions: _____

_____

Physician's Name _____ Phone _____

Physician's Signature _____

MEDICATION MUST BE BROUGHT TO THE SCHOOL OFFICE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACIST OR PHYSICIAN.

Should a change in any of the above information occur, a revised written Physician's Statement must be submitted.

I understand that under the provisions of Florida Statute 232.46, school personnel cannot be held liable for reactions or side effects from the administration of the medication. I also grant permission for school personnel to contact the physician if there are any questions or concerns about the medication. I have read the guidelines as outlined in the HTLS Parent Handbook and agree to abide by them.

_____

Parent/Guardian Signature **Immediate Contact Phone Number**