Zion Lutheran School
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AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION

Name: _____ Date of Birth: _____

HEALTH CARE PROVIDER completes this section:

I have determined that the medication named below is necessary during the school day.

Diagnosis or reason for medication: _____

Name of medication: _____ Dose: _____

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other_____

If medicine is given DAILY, at what time? _____

If medicine is to be given WHEN NEEDED, describe indications: _____

_____

How soon can it be repeated? _____

Is child allowed to carry and self-administer "rescue inhaler"? Yes ☐ No ☐
If **yes**, I have trained this student in the purpose and appropriate method and frequency of use.

Length of time this treatment is recommended: ☐ Current School Year ☐ Other: _____

Significant side effects: _____

Date: _____ Health Care Provider Signature: _____

Phone #: _____ Print Name: _____

Fax #: Address:

PARENT/GUARDIAN completes this section:

I request that my child be allowed to take the medication as described above.
I request that authorized school staff assist my child in taking the medication(s) described above.
I understand that school staff will attempt to administer medication in a timely manner.
I will provide the medication in the original, properly labeled container.
I give my permission for the exchange of information between the school staff and health care provider.
I understand that my signature indicates my understanding that the school district and school staff shall not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and in accordance with Zion Lutheran School policy.

_____

Parent/Guardian Signature and Date

_____

Daytime Phone **Emergency Phone**