



Faith Lutheran School
8701 Adams Street Lincoln, NE 68507
School 402-466-7402

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____

Birth Date: _____

Teacher: _____

Grade: _____

Name of Medication

Dosage

Route

Time of day

Last dosage given at: _____

Period of Administration (date) _____ to (date) _____

Student is capable of self-administration of medication with supervision ___ Yes ___ No

Inhalers: _____

Indicate if student must carry on his/her person

Possible side effects of this medication _____

Emergency procedure in case of serious side effects _____

I request and authorize the Faith Lutheran School to administer the above named medication (supplied by me) to my child. I accept ultimate responsibility for monitoring the effects of this medication.

PARENT

PARENT name printed

Phone # _____

Date: _____