Faith Lutheran School
8701 Adams Street Lincoln, NE 68507
School 402-466-7402
Fax 402-466-3857

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

Class: _____

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 _____