AUTHORIZATION FOR MEDICATION _____

ST. MATTHEW LUTHERAN SCHOOL (School Year)

(248) 624-7677 FAX: (248) 624-0685

Dear Parent and Physician:

It is the policy of St. Matthew Lutheran School to have a physician's written authorization for school personnel. When they are involved with a student taking medication during school hours. The only medication which will be dispensed will be that prescribed by a physician. This will include such simple home remedies as aspirin, cough medicine, eardrops, etc. This authorization is valid for the current school year only. The information will be handled in a confidential manner.

PARENTS, please complete this section.

Student's Name: _____ Birth Date_____

I hereby authorize school personnel to give medication to the above named student according to the physician's directions as given below.

Parent's Signature: _____ Date: _____

PHYSICIAN, please complete Parts 1 or 2 along with 3:
Please instruct pharmacist to label bottle with child's name, name of medication, and dosage.

1. Name of Drug: _____

Routine: _____

Give at (hour): _____

For period: _____
(Date)

To: _____
(Date)

2. Emergency: _____

Circumstances for giving:

_____

_____

If not better in _____
(Length of time)

then _____

3. Directions for giving: (Amount and method) _____

Reason for medication: (Diagnosis, anticipated effects) _____

_____

Undesired reactions: _____

Comment: (Include any request for personnel/teacher observation and report):

_____

Physician's Signature and Date: _____

Physician's Printed Name/Stamp_____
Address: _____ Telephone: _____

For students in 6th – 8th Grade ONLY: If an inhaler is prescribed, I authorize the inhaler to be carried by the student:

_____ YES PHYSICIAN SIGNATURE: _____DATE: _____