Bethany Lutheran School
Medication Administration Authorization
2018-2019

Student Name_____ Grade_____ Birthday____ /____ /_____

The school employee who administers any medication will e-mail you with time and dosage information so you are aware of any medication that is given. Please provide the e-mail(s) to which you would like this information sent.

Preferred E-mail(s)_____

DESCRIBE ANY MEDICAL CONCERNS FOR THIS CHILD (i.e. known allergies, dietary restrictions, sensitivities, etc.):

_____

_____

_____

OVER-THE-COUNTER MEDICATION AUTHORIZATION

- ☐ Ibuprofen (Advil, etc.)
- ☐ Acetaminophen (Tylenol, etc.)
- ☐ Antihistamine (Benadryl, etc.)
- ☐ Cough Drops
- ☐ First Aid Antibiotic Ointment (Neosporin, etc.)
- ☐ Anti-Itch Cream (Cortisone 10, etc.)
- ☐ Antacid (Tums, Pepto Bismol, etc.)
- ☐ Sunscreen (only used on day-long field trips)
- ☐ Other:_____

I hereby give my permission for the above named student to take the medications checked above.
I understand that any school employee who administers these medications in accordance with written instructions shall not be liable for damages as a result of an adverse reaction suffered by the student as a result of the medication.

_____ _____

Parent/Guardian Signature Date

*Please see the back side of this form for information about providing any other over-the-counter or prescription medication needed throughout the year (i.e. Zyrtec, Claritin, etc.)

OVER →

ADDITIONAL MEDICATION AUTHORIZATION
including inhalers, epi-pens, and allergy medicines
(over-the-counter or prescription)

Please complete this chart for any medications to be administered at school. This includes both prescription and over-the-counter medicines not included in the list on the front page. Ex. inhalers, epi-pens, allergy medicines, etc.

What medicines to use	When to use	How much (dosage)	Additional

All medications must be sent in a clearly marked container which states the name of the medication and the dosage. A signed note from the physician (or the signing of this form by the physician), including timing and dosage information, must accompany any prescription medication.

****PLEASE DO NOT SEND MEDICATIONS IN PLASTIC BAGGIES!****

I hereby give my permission for the above named student to take the prescription medication listed above. I understand that any school employee who administers these medications in accordance with written instructions shall not be liable for damages as a result of an adverse reaction suffered by the student as a result of the medication.

_____ _____

Parent/Guardian Signature Date

_____ _____

Physician Signature Date

(not needed if physician has signed a separate note for the prescription medication indicating timing and dosage)