ST. PETER LUTHERAN SCHOOL

Prescription/Non-Prescription Medication Authorization Form

Student Name:				Birthdate:		
						Date:
To be completed by po	ırent/gua	rdian:				
Medication (in original container)	Dose	Time To Be Given	Form/Route*	Possible Side Effects	Adverse Reactions (Report to Parent)	
*Routes: oral(pill/caps topical (eye drop, ointr		•	-	ulizer), topical skin ap	plication,	
List symptoms/condition	ons under	which medications	ordered as ne	eded (p.r.n.) are to be	e given:	
If (p.r.n.), MINIMUM a	mount of	time between dose	s:			
Reason for medication	(optional): Medication	#1:			
		Medication	#2:			
Special Instructions:						
Start Date: Stop [Stop Date	te:		
I request and give pern						
receive the above med school personnel to sh		_		•	ne physician's staff and	
Parent's Name:				Phone #:		
Parent/Guardian Signature:				Date:		