Authorization to Dispense Medication

Student Name:_____Grade/Teacher:_____

Name of Medication:_____

Dosage to be given:_____

Start Date:_____ Date to discontinue (if needed):_____

Special Instructions:

PRESCRIPTION MEDICATION MUST BE AUTHORIZED BY YOUR PHYSICIAN. PLEASE ATTACH A TREATMENT PLAN OR MEDICATION ORDER SIGNED BY THE CHILD'S PHYSICIAN. PRESCRIPTION MEDICATION SHOULD BE IN LABELED CONTAINER FROM PHARMACY.

RELEASE OF LIABILITY

I/We the undersigned parent/guardian, request First Lutheran School to administer the medication described above. I am aware of the hazards and possible consequences involved with regard to the administration of the above-named medication, and in consideration of FLS consenting to administer this medication, DO HEREBY RELEASE First Lutheran Church and School, its agents, staff, faculty, or any other person acting on behalf of FLS from any and all liability which may result from acts associated therewith; and, release the school from any responsibility regarding schedule dosages and contacting students regarding administration time.

Print Name:_____

Signature:_____

Relationship to student:_____