AUTHORIZATION FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

Lutheran School Association
2001 E. Mound Road
Decatur, IL 62526
K-8 (217) 233-2001
High School (217) 233-2000
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To the Physician:

When it is necessary for a student to self-administer or have the school nurse administer medication during the day, the following information must be provided to the school from the physician:

Name of disease or illness involved ____

____________________________________ should take ___________________________
(Name of Student) (Dosage)

of ____ at ______________________
(Name of Medication) (Time of Day)

for ____.
(Period of Time)

The desired effects of this medication are: ____

____

The possible side effects of this medication are: ____________________________________

____

Physician Signature ____________________________________ Date ________________

To the Parent or Guardian:

I request that my child, ____ take the medication
(First and Last Name)

above as prescribed by the physician.

Parent/Guardian Signature _______________________________ Date ________________

In addition to the above information, the medication container must be labeled by the pharmacist and/or physician including:

1. **Name of student**
2. **Name of medication**
3. **Amount to be taken**
4. **Time of day to be taken**
5. **Time interval between doses**
6. **Physician's name**
7. **Date of prescription**

* The Lutheran School Association, along with its employees and agents, assume no liability (except for willful and wanton misconduct) as a result of any injury arising from the pupil's self-administration or the school nurse administering of any medications.

* Absolutely no antibiotics will be given at school unless ordered more than 3 times a day.

* Information may be shared with appropriate personnel for health and educational purposes.