

**Parent(s)/Guardian Medication Authorization Form
Over-the-Counter/Prescription Medication**

Student's Name: _____ **Date of birth:** _____

Address: _____ **Grade:** _____

As the parent and guardian of the above mentioned student, I give St. Lucas Lutheran School permission to administer the following medication(s)

to my child for the following reason or diagnosis _____

_____.

Medication/Dosage (mg, cc, ml, etc)	How it is to be given	How often	Start Date	Stop Date	Considerations/ Side Effects
1.					
2.					
3.					

As the parent or guardian of the above mentioned student, I will keep St. Lucas Lutheran School aware of any changes in medication(s) profile or health concern of my child.

Parent(s) Guardian Signature: _____ **Date:** _____