(FORM: E) **Office of the School Nurse**

Christ Community Lutheran School

Middle School Campus
110 W. Woodbine Ave.
Kirkwood, MO 63122
(314)822-7774 FAX: (314)822-5472

Elementary Campus (K-5)
8749 Watson Rd.
Webster Groves, MO 63119
(314)961-6595 FAX: (314)961-5166

MEDICATION AUTHORIZATION FORM

Students needing medication to be given during school hours must have a medication authorization form on file in the student health record. *These forms must be completed and signed by the physician and parent and returned to the school office before any medication may be given. All medications including over-the-counter medications must have an authorization form completed.*

Parents must supply the medication in a container with the original label, appropriately labeled for administration during school hours. Medicine to be given at school is to remain at school for the period of time it is to be given. Please have your pharmacist label two containers for prescription medications, one for school and one for home.

I hereby request school personnel to supervise the administration of the medication for my child, named below. It is understood that the school is administering medication to my child and/or supervising the administration thereof gratuitously and in reliance on my request and the accompanying physician request. Accordingly, I assume all responsibility regarding this matter and hereby release the school, its personnel and governing administrative bodies from any and all liability as to injuries or ill effects of any kinds which may be caused thereby, including those ill effects caused by school personnel failure to remind students to take the prescribed medication and to monitor its dosage.

Child's Name ______________________________ Grade __________ D.O.B. _______________

☐ Tylenol _____ # reg. strength 325 mg tablets ☐ Ibuprofen ______# of 200 mg tablets

Other Medication ______________________________

Dosage/Time to be given ______________________________ Total Daily Dosage __________________

Starting date for medication ______________________________ Discontinue medication on __________________

Reason for taking medication ______________________________

Possible side affects ______________________________

Student allergies to past medications ______________________________

Physician Name ______________________________ **Physician office number** ______________________________

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Physician Signature **Date**

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Parent Signature Date

REQUEST FOR CHILD TO SELF-ADMINISTER MEDICATION

I have trained the child above and consider the child to be capable of self-administering an inhaled medication, an epi-pen, or insulin. *Only a rescue inhaled medication for asthma or an epi-pen for severe allergic reactions may be carried by the student.*

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Physician Signature **Date**

In accordance with the physician's request, we want our child to self-administer the above named medication. I realize there are additional responsibilities in doing so and assume responsibility for those liabilities.

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Parent Signature Date