

MEDICATION AUTHORIZATION FORM

Date: _____

Dear Staff and Administration of Good Shepherd Evangelical Lutheran Elementary School

Please receive this as my request for my child to self administer medication. I hereby request administration approval. If approval is granted, the following items apply:

Name of Student: _____

Name of Medication: _____

Dosage: _____

Time to be administered: _____

Route of Administration: _____

Duration of Administration: _____

Frequency of Administration: _____

This request/approval becomes void 8 June of every calendar year or upon expiration of prescription.

A photocopy of this document is deemed as valid as the original.

Parent/Legal Guardian

Date

Witness

Date

Administration Approval by: _____

Date: _____