



LUTHERAN SOUTH ACADEMY

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PHYSICIAN'S MEDICATION AUTHORIZATION

Authorization for medication to be taken during school hours

STUDENT _____ GRADE _____ TEACHER _____

DATE OF BIRTH _____ DIAGNOSIS _____

MEDICATION _____ DOSE _____

ROUTE _____ TIME _____

*Medication is taken at home as follows: Dose _____ Time _____

Side effects _____ Special Instructions _____

MEDICATION _____ DOSE _____

ROUTE _____ TIME _____

*Medication is taken at home as follows: Dose _____ Time _____

Side effects _____ Special Instructions _____

PHYSICIAN SIGNATURE

DATE

PRINTED NAME

PHONE NUMBER

*My signature indicates that I give permission for LSA faculty to administer the above medication to my child as requested by the physician. I understand that I am giving consent for the school nurse to discuss any concerns regarding this medication with the prescribing healthcare provider, if deemed necessary. It is the parent/guardian responsibility to notify the school nurse of any changes to the original prescription and provide to the school a **new authorization form**, reflecting changes in the original order. Nurses **cannot** accept from a parent without written physician confirmation, a request for change in dosage, timing or route of administration. In the event home dose is missed, parent may call and give verbal phone request for missed dose to be given at school. I understand medications will only be administered if they are in the original bottle, correctly labeled and age dose appropriate. I understand that LSA and its employees will not be held liable for any injury or side effects from administration of this medication. I understand that this medication authorization is only valid for one school year.*

PARENT SIGNATURE

DATE