LUTHERAN SOUTH ACADEMY
12555 RYEWATER DRIVE · HOUSTON, TX 77089 PHONE 281.464.8299 WWW.LUTHERANSOUTH.ORG

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**