IMMANUEL LUTHERAN SCHOOL
OLIVETTE

Dispensing Medication Authorization Form

Child's Name _____ **DOB:** ____/____/____
First Middle Last Month Day Year

Part I: To be completed by Physician

Diagnosis _____

_____ _____ _____ _____
Medication Route of administration Dosage Time/frequency

If PRN, state frequency or indication _____

Duration of Treatment Dates _____

Possible side effects and adverse reactions _____

Other recommendations _____

Is this drug covered by the psychotropic drug law? _____ Yes _____ No

Part II: To be completed by Parent/Guardian

I authorize the school to see that my child _____ receives the medication

prescribed by _____.

Parent's/Guardian's name (printed or typed) Telephone numbers

_____ _____
Parent's/Guardian's signature Date

Please list all medications that your child is taking at home: _____

Part III: Addendum Completed by Physician AND Parent/Guardian

In cases where self-administration of medication is deemed necessary or preferable by parents and the physician, the parent and physician must assume all responsibility.

I grant permission for **the above-named student** to self administer this medication and will assume all liability for the use and/or misuse of this medication. _____ Yes _____ No

_____ _____
Physician's Name (printed or typed) Telephone number

Physician's signature Date