Medication Authorization
Hillcrest Lutheran Academy - Upper and Lower Campus
School Year _______________

Parents/Students must provide all Medications in original, labeled containers (in English), prescription and over-the-counter medications

Name of Student:_______________________________________Birthdate:_________________Grade:_________

Medication	Strength	Dose	Time	Route

Signature of Medical Doctor/Licensed Prescriber:___________________________________

Name of Physician/Licensed Prescriber:____

Clinic Address:____

Clinic Phone #:_____________________________Fax#:______________________________

Medical Condition:____

Possible Side Effects or Other Considerations:_______________________________________

Expected Duration of Treatment:____

Parent/Guardian Authorization

- I request the above medications be given as ordered by physician/licensed prescriber. I also request the medication be given on field trips, as prescribed.
- I release school/dormitory personnel from liability in the event adverse reactions result from taking the medications.
- I will notify the school of any changes in the medications. (ex: dosage change,medication discontinued)
- I give permission for the school nurse to communicate with the child's teachers about the child's health condition and the action of the medication.
- I give permission for the [1]school nurse to consult with the above named student's physician/licensed prescriber regarding any questions about the above listed medications or conditions.

Parent/Guardian Signature:____Date:__________________

Relationship:________________________________ Daytime Telephone #:_________________________________

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