St. Paul Lutheran Church & School

AUTHORIZATION FOR MEDICATION FORM

PLEASE PRINT ALL INFORMATION, EXCEPT SIGNATURE

Student's Full Name _____

Name of Medication _____

Rx Number _____

Time Medication is to Administered _____

Amount of Medication to Administer _____

Date to be Administered _____

Signature of Parent/Guardian _____

Date	**Time Given**	**Dosage**	***Adverse Reactions** note NONE if applicable	**Administered By**

Date	Time Given	Dosage	***Adverse Reactions** note NONE if applicable	**Administered By**