

# Concordia Lutheran School

Parent(s)/Guardian **Over the Counter Medication** Authorization Form

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Grade: \_\_\_\_\_

As the parent/guardian of the above mentioned student, I give CONCORDIA LUTHERAN SCHOOL administration and staff permission to administer the following medication(s) to my child for the following reason or diagnosis:

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Medication/Dosage (mg, cc, ml, etc)	How it is to be given	How often	Start Date	Stop Date	Considerations/ Side Effects
1.					
2.					
3.					

As the parent/guardian of the above mentioned student, I will keep the school aware of any changes in medication(s) profile or health concern of my child.

As a part of the Wisconsin Statute Chapter 118.29, Administration of Drug to Pupils and Emergency Care, school districts are required to have permission from a medical provider and/or parent to administer medications at school. As part of this authorization form, school employees may contact the medical provider with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above with parent permission.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_