Trinity Lutheran School

Authorization to Administer Medication

Student Name_______________________________________ Age__________

Medication____

Reason____

Dosage____

Frequency____

I, _________________________, parent or legal guardian of _______________

__________________________, do hereby authorize school personnel to administer medication to my child during school hours.

Date: _________________ Signed: ___________________________________
Parent or Legal Guardian

All prescription medication must be brought to school in the original prescription bottle.

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