Zion Lutheran School

Authorization to Administer Medication

School Year 2026-2027

Children Enrolled	Grade	Special Health Notes-List all medical diagnoses, allergies, health conditions and an action plan if necessary.

Parent's Authorization

I do hereby authorize Zion Lutheran School to administer medication to my child,

_____. I understand that I will be responsible for supplying this medication to the school. This medication will be kept only in the school office and only dispensed from the school office. Direction of medicinal usage will be kept by the school secretary for each medication given. I understand that the school and school personnel incur no liability for injuries occurring when administering medications, asthma medication, an epinephrine auto-injector, or an opioid antagonist.

Name of Medication: _____

Please circle one: Prescription Non-Prescription

Type of Medication (tablet, liquid, capsule, inhaler): _____

Dosage: _____ Time(s) to be given: _____

For students with medical diagnosis of asthma, diabetes, and any other diagnosis that require management while at school, an Action Plan from the child's doctor needs to be submitted to the school office annually to be kept on file in the office and distributed to any staff members who would need to help in the management of the condition.

For headaches, I allow my child to take at school: ____ Ibuprophen _____Tylenol

_____ _____

Parent or Guardian Signature Date

Note: The parent's authorization is only valid until the medication is used up. In the case of prolonged medication, the validation may continue until the end of the school year. Prescription medication must be in a pharmacy issued bottle with the child's name and name of the physician.