



The Center for Lutheran Education  
**Lutheran High School of San Diego**



**Physician's Recommendation for Medicine**

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

Home Phone: \_\_\_\_\_ Parent's Wk or Cell Phone: \_\_\_\_\_

This form must be completely filled out and signed annually by the student's parent/guardian and the student's authorized health care provider before the student can be assisted with the administration of medication by a staff/faculty member of Lutheran High School.

**To be Completed by Health Care Provider:**

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Method: \_\_\_\_\_ Schedule Given: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_ Duration: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Method: \_\_\_\_\_ Schedule Given: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_ Duration: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Health Care Provider's Name (Print): \_\_\_\_\_

Health Care Provider's Signature: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Date: \_\_\_\_\_

I agree that Lutheran High School, its officers, faculty and staff shall not be held liable for any loss, damage, injury or liability of any kind to any person caused or arising from acts, omissions or negligence of Lutheran High School, its officers, faculty and staff related to the administration of medication to my child.

**I have read and understood this form and consent to the above provisions.**

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