

Youth Ministry Prescription Medication Authorization

Youth Leader Carry

Date of Trip: _____

Age of Student: _____

My permission is hereby granted to St. Luke's Youth ministry to administer prescribed medication to _____
(Student's Full Name)

Name of Medication: _____

Dosage/Amount given & how often: _____

Times to be given: _____

Additional special instructions: _____

Note: All medications should be given in their original containers thus providing us with necessary information on the drug.

Parent/Guardian Signature: _____

Date: _____

Youth Ministry Prescription Medication Authorization

Student Carry

Date of Trip: _____

Age of Student: _____

I hereby authorize _____ to carry
(name of student)

and self-administer the medication(s) listed below. I understand that my child and I are responsible for administering the medication properly and St. Luke's Youth ministry and its leaders will not be responsible for any improper usage.

Name of Medication: _____

Dosage/Amount given & how often: _____

Note: All medications should be given in their original containers thus providing us with necessary information on the drug.

Parent/Guardian Signature: _____

Date: _____