Medical Treatment Authorization

I hereby give permission to Living Stones Christian School staff members to administer medical care to my child, _____, as directed below or as needed. If treatment is to be given as needed, I authorize Living Stones Christian School personnel to determine when treatment is needed, and I will not hold Living Stones Christian School or its personnel accountable for negligence in this regard.

Treatment is to be given **as directed below** or **as needed**. (Please circle one)

1. Medicine Name: _____ Dosage:_____

   Date(s) of administration: Start:_____ End:_____

   Times of day to administer medicine and/or medical treatment:_____

2. Medicine Name: _____ Dosage:_____

   Date(s) of administration: Start:_____ End:_____

   Times of day to administer medicine and/or medical treatment:_____

Parent Signature:_____ Date:_____

Date	Medication Name/ Medical Treatment	Dosage Given	Time Dispensed	Staff Signature

LIVING STONES CHRISTIAN SCHOOL
1407 Victory Lane
Alvin, Texas 77511
(281) 331-0086 • www.lscs.org