

Diocesan Authorization for Medication Form

Date:
Student Name:(Please print)
(Please print)
It is necessary that medication be given as follows:
Name of medication: (Brand Name; also, Medication Name as it appears on container (if generic equivalent)
Prescription No.:
Color, if applicable:
Please circle form of medication:
□ Tablet □ Pill □ Capsule □ Inhalation □ Liquid □ Other/Specify
Dosage:(Amount to be given)
(Amount to be given)
How often/What time:
** No injection will be given, except in an extreme emergency, such as allergy to bee sting or the like.
The parent knows of this request and is in full agreement that this medication will be supplied as needed. Should the student manifest any of the following symptoms caused by the medication, please contact the parent or my office.
REMARKS:
KNOWN ALLERGIES:
Print Parent's Name Parent's Signature
PLEASE PRINT PHYSICIAN'S NAME:
Physician's Signature Physician's Telephone Number