ARCHDIOCESE OF LOS ANGELES
MEDICATION AUTHORIZATION AND PERMISSION FORM

Sacred Heart School

625 W. Kettering St. ♦Lancaster, CA 93534
(661) 948-3613 ♦ Fax: (661) 948-4486

Part **A, B & C** to be completed by a licensed Physician
Part **D** by Parent/Guardian – *please print*

A.

Last Name of Student _____ First Name _____ Sex _____ Birth Date _____

Purpose of Medication or Diagnosis _____ Name of Medication _____

Dosage Prescribed _____ Time Schedule at School _____ Dose Form (Tablet/Liquid) _____ Color _____

Date of Prescription _____ Length of Time this Medication will be necessary _____

B. Physician's Recommendations. (Check where applicable)

_____ Please notify this office if patient misses medication at school.

_____ Medication may have adverse effects (explain)_____

_____

_____ Special instructions and/or comments_____

_____

C. Physician's Authorization. The student for whom this medication is prescribed is under my care.

Print Name of Licensed Physician _____ Signature of Licensed Physician _____

Address _____ Telephone _____ Date _____

D. Permission for Medication to be Taken During School Hours

I request that my child, _____, be permitted to receive and to be assisted/supervised in taking the above prescribed medication at school. I will comply with the policies and procedures determined by the school district.

Date _____ Day Telephone _____ Emergency Telephone _____

_____
Signature of Parent / Guardian