Authorization for PRESCRIPTION Medication

Student Name ____ Grade __________

In accordance with Diocesan policy #4108 all prescription medication must be in the original, properly labeled, container. The container should be child-proof and labeled by a pharmacist or physician. The original container is to be accompanied by this completed form.

Name of prescribing physician: ____

Name of medication: ____

Physician's directions:

a. Amount to be given ____

b. Time to be given ____

c. Date(s) to be given ____

d. Reason ____

Curtailment of specific activities (if any) ____

Other medications the student is taking ____

Signature of Physician _____________________________________ Date _______________

I HEREBY CERTIFY THAT I HAVE READ THIS DOCUMENT IN FULL AND THAT I HAVE THE LEGAL AUTHORITY TO CONSENT TO THE ADMINISTRATION OF THIS MEDICATION:

Parent/Guardian signature ____

Parent/Guardian printed name ____

Witness (school employee) signature ____

Witness printed name _______________________________________ Date ______________

THIS RELEASE IS TO BE RETAINED IN STUDENT'S MEDICAL FILE.