ARCHDIOCESE OF LOS ANGELES

Medication Authorization and Permission Form

One form per medication

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** **Grade**

_____ _____

Name of Medication **Purpose of Medication**

_____ _____ _____

Dosage **Frequency (times to be admitted)** **Dose Form (tablet / liquid)**

_____ _____

Date of Prescription **Length of Time Medication will be Necessary**

B. Physician Recommendations (check where applicable)

❑ **Notify parent if student misses medication at school**

❑ **Medication may have adverse effects (explain):** _____

_____

❑ **Special instructions and / or comments:** _____

_____

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

_____ _____

Printed Name of Licenced Physician **Signature of Licenced Physician**

_____ _____

Physician Telephone Number **Date**

D. Parental / Guardian Permission for Medication to be Taken During School Hours

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

_____ _____ _____

Date **Day Telephone** **Primary Emergency Contact Number**

_____

Signature of Parent / Guardian