Medication Authorization and Permission Form

Archdiocese of Los Angeles

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

Parent/Guardian Signature_____