Authorization for PRESCRIPTION Medication

Name of Student _____ 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 a physician. The original container is to be accompanied by this completed form.

Name of physician prescribing the medication: _____

Name of the medication: _____

Physician's Directions:

a. Amount to be _____

b. given: Time to be _____

c. Date(s) to be given: _____

d. Reason: _____

Curtailment of specific school activities (if any): _____

Other medications which the student is taking: _____

Parent/Guardian Signature_____Date: _____