

ARCHDIOCESE OF LOS ANGELES MEDICATION AUTHORIZATION AND PERMISSION FORM

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

_____ Name of Medication
Purpose of Medication or Diagnosis

_____ Color
Dosage Prescribed Time Schedule at School Dose Form(tablet/liquid)

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

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.

_____ Signature of Licensed Physician
Print Name of Licensed Physician

_____ Date
Address Telephone

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.

_____ Emergency Telephone
Date Day Telephone

Signature of Parent/Guardian