ARCHDIOCESE OF LOS ANGELES
MEDICATION AUTHORIZATION AND PERMISSION FORM

Parts 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

_____
Signature of Parent/Guardian