

St. John Baptist de la Salle School
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

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) _____

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

