

OUR LADY OF REFUGE SCHOOL

MEDICATION AUTHORIZATION AND PERMISSION FORM

Parts A, B, and C below to be completed by a licensed physician.

A. _____
Last name of Student First Name Gender Birthdate

Diagnosis/Purpose of Medication Name of Medication

Dosage Prescribed Time Schedule @ School Dose Form 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 side effects (please 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

To be completed by the student's parent or guardian.

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 and the archdiocese. I understand that all medication must be provided to the school in its original container.

Date Day Phone Emergency Phone

Signature of Parent/Guardian