Archdiocese of Los Angeles
Sacred Heart School
Medication Authorization and Permission Form

Part A, B & C to be completed by a licensed Physician

Part D by parent/guardian – *please print*

_____ _____

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 Necessar

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 _____

_____

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

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