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) _____

_____

_____ 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 the school. I will comply with the policies and procedures determined by the school district.

_____ _____ _____
Date Day Telephone Emergency Telephone

_____
Signature of Parent/Guardian