Mother of Christ Catholic School and Learning Center

Authorization for Medication

Name of Student _____ Grade _____

Date: _____ Physician: _____

Physician's Address: _____

Physician's Phone Number: _____

Diagnosis:

_____

Medication and Dosage Prescribed:

_____

_____

Purpose of Medication:

_____

Possible Side Effects:

_____

Directions for Administration by School Personnel:

_____

_____

Length of Time to Be Administered (i.e.: 10 days, until finished, all year, etc.)

_____

My permission is hereby granted to the school principal or their specified, delegated personnel to administer the prescribed medication above to my child.

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____