



# Diocesan Authorization for Medication Form

**Date:** \_\_\_\_\_

**Student Name:** \_\_\_\_\_  
(Please print)

It is necessary that medication be given as follows:

**Name of medication:** \_\_\_\_\_  
(Brand Name; also, Medication Name as it appears on container (if generic equivalent))

**Prescription No.:** \_\_\_\_\_

**Color, if applicable:** \_\_\_\_\_

**Please circle form of medication:**

Tablet   Pill   Capsule   Inhalation   Liquid   Other/Specify \_\_\_\_\_

**Dosage:** \_\_\_\_\_  
(Amount to be given)

**How often/What time:** \_\_\_\_\_

\*\* No injection will be given, except in an extreme emergency, such as allergy to bee sting or the like.

The parent knows of this request and is in full agreement that this medication will be supplied as needed. Should the student manifest any of the following symptoms caused by the medication, please contact the parent or my office.

**REMARKS:** \_\_\_\_\_

**KNOWN ALLERGIES:** \_\_\_\_\_

\_\_\_\_\_  
**Print Parent's Name**

\_\_\_\_\_  
**Parent's Signature**

**PLEASE PRINT PHYSICIAN'S NAME:** \_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature**

(\_\_\_\_\_) - \_\_\_\_\_  
**Physician's Telephone Number**