# Authorization for PRESCRIPTION Medication

School Year: 2026-2027

**Name of Student**_____**Grade**_____

In accordance with Diocesan policy #4108 all prescription medications must be in the original properly labeled container. The container should be “child-proof” and labeled by a pharmacist or a physician. The original container is to be accompanied by this completed form **AND a note signed by the physician stating this medication must be administered at school.**

Name of physician prescribing the medication:_____

Name of the medication:_____

## Physician’s Directions

| | |
|---|---|
| **Amount to be given** | |
| **Time to be given** | |
| **Date to be given** | |
| **Reason** | |

Curtailment of specific school activities (if any):_____

Other medications which the student is taking:_____

**Parent/Guardian Signature:**_____**Date:**_____

**Printed Name:**_____