AUTHORIZATION FOR MEDICATION

OUR LADY OF LOURDES PARISH SCHOOL

NAME OF STUDENT:_____ CLASS_____

TREATMENT PLAN (to be completed by Physician)

DATE: _____ _____

Physician

DIAGNOSIS: _____ _____

Address

_____ _____

Telephone

MEDICATION AND DOSAGE PRESCRIBED: _____

_____

POSSIBLE SIDE EFFECTS:_____

_____

PURPOSE OF MEDICATION: _____

DIRECTIONS FOR ADMINISTRATION BY SCHOOL PERSONNEL: _____

_____

LENGTH OF TIME TO BE ADMINISTERED (i.e.: 10 days, until finished, all school year)

_____

_____

Signature of Physician

PARENTAL PERMISSION (to be completed by Parent or Guardian)

DATE: _____

My permission is hereby granted to the School Principal or her specified delegated personnel to administer the prescribed medication stated above to my

_____ _____

Relationship Signature of Parent/Guardian