Diocese of Palm Beach

Diocesan Authorization for Medication Form

Date: _____

Student name (please print legibly : _____

It is necessary that medication be given as follows:

Name of medication: _____

Brand Name/Medication Name as it appears on container - if generic equivalent

Prescription No.: _____ Color if applicable: _____

Please circle the form of medication:

Tablet Pill Capsule Inhalation Liquid Other/Specify: _____

Dosage: _____ How often/What time given: _____

**NO injections 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: _____

_____ _____

Parent Name (Print) Parent Signature

Please print Physician's name: _____

Physician's Signature