

**ARCHDIOCESE OF LOS ANGELES
MEDICATION AUTHORIZATION AND PERMISSION FORM**

Part A, B & C to be completed by a licensed Physician

Part D by parent/guardian – *please print*

A. _____
Last Name of Student First Name Sex Birth Date

Purpose of Medication or Diagnosis Name of Medication

Dosage Prescribed Time Schedule at School Dose Form (tablet/liquid) Color

Date of Prescription Length of Time this Medication will be Necessary

B. Physician's Recommendations. (check where applicable)

_____ Please notify this office if patient misses medication at school.

_____ Medication may have adverse effects (explain) _____

_____ Special instructions and/or comments _____

C. Physician's Authorization. The student for whom this medication is prescribed is under my care.

Print Name of Licensed Physician Signature of Licensed Physician

Address Telephone Date

D. To the Parent/Guardian: The inhaler may be carried by the student and used as prescribed after this form has been filed with the school health office.

Permission for Medication to be Taken During School Hours

I request that my child, _____, be permitted to carry and use an inhaler at school during school hours as prescribed by his/her doctor. I will comply with the policies and procedures determined by the school district.

Parent Signature

Date Day Telephone Emergency Telephone

9/01/02