

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. Student Information

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
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