

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

**Part A, B & C to be completed by a licensed physician, Part D to be completed by parent/guardian - Please print clearly**

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. Permission for Medication to be Taken During School Hours**

I request that my child, \_\_\_\_\_, be permitted to receive and to be assisted/supervised in taking the above prescribed medication at school. I will comply with the policies and procedures determined by the school district.

\_\_\_\_\_  
Date                      Day Telephone                      Emergency Telephone

\_\_\_\_\_  
Signature of Parent/Guardian