ST. PAUL CATHOLIC SCHOOL
PRESCRIPTION MEDICATION FORM

Requirements for **prescription** medication:

1) ALL **prescription** medication must come to school in the prescriptive container that was given by the pharmacy or the medication will not be administered to the student.
2) This form must be **completely filled out and signed by the physician** or the medication will not be administered to the student.

Family Physician

This is to certify that _____is being attended and treated by me. It is essential that he/she be given the following medication in the dose indicated during school hours.

_____

Diagnosis

_____

Name of Medication

_____

Dosage Schedule and Route

_____

Frequency

_____

Possible Side Effects (if any)

Length of Time to be given: (Please check one) _____Indefinitely
_____To be renewed
_____To be discontinued on _____
Date

_____ _____

Signature of Physician **Date**

_____

Address

_____

Name of Student Phone

_____

Address

AUTHORIZATION TO ADMINISTER **PRESCRIPTION** MEDICATION BY SCHOOL PERSONNEL

I,_____request the school personnel to administer to
(Parent or Guardian)
_____grade_____, the medication prescribed by
Student

_____ _____

(Physician's Name) **Signature of Parent/Guardian** **Date**