Our Lady of Sorrows Academy Medication Authorization

*Parental Permission (To be completed by Parent or Guardian for non-prescription-OTC **and** prescription medicine)*

Name of Student_____Date: _____

My permission is hereby granted to school personnel to administer prescribed medication below to my_____(relationship),_____(name of student)

Signature of Parent/Guardian:_____Phone:_____

Non-prescription (OTC) medicine: Please list name of medicine and dosage to be administered with start and stop dates.

_____

_____

Prescription medicine or Epi Pen: <u>Physician must complete</u>.

Date:_____

Physician:_____

Address:_____

_____

Phone:_____

Diagnosis:_____

Medication and Dosage Prescribed:_____

Side Effects:_____

Purpose of Medication:_____

Direction for Administration by School Clinic Personnel:_____

_____

Signature of Physician:_____