

LANSING CATHOLIC HIGH SCHOOL

MEDICATION AUTHORIZATION FORM

DATE: _____

STUDENT'S NAME _____
(last) (first)

I hereby request and authorize the school administrator or assignee to administer the prescribed medication indicated on this form as directed by our physician. I agree to supply the school with the medication in its original container, legally labeled.

Furthermore, I release Lansing Catholic High School and shall indemnify the aforementioned from any liability or damage which may result to my child from the administration of said medication as prescribed by our physician. Any changes to said medication will result in completion of a new authorization form.

(Signature of Parent/Legal Guardian)

PHYSICIAN'S ORDER

You are directed to give _____ his/her
(name of student)

_____ in the amount of _____
(name of medication) (specify dosage)

at _____ AM/PM, daily or as follows _____
(time) (frequency)

from _____ until _____
(starting date, use MM/DD/YY) (ending date, use MM/DD/YY format)

Special Instructions/Precautions: _____

(date)

(physician's signature)

(doctor's office number)