MEDICATION AUTHORIZATION FORM

Date: _____________

STUDENT'S NAME: ____
(LAST) (FIRST)

I hereby request and authorize the school administrator or assignee to administer the medication (over-the-counter and/or prescribed) indicated on this form as directed below. I agree to supply the school with the medication in its original, legally labeled container. Any prescribed medication will include a physician's signature below.

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

____
(Parent/Legal Guardian)

* *

______________________________is to be given his/her ________________________
Name of Student Name of Medication

in the amount of ______________________________ at _______________AM/PM, daily
Tablets/Capsules/Units Hour(s)

from ___________ to ___________, or as follows:
Month/Day/Year Mont/Day/Year

____

____

PRESCRIPTION AUTHORIZATION:

Name of Medication: ____

Special instructions/Precautions ____

____

____________ ______________________________ ____________
Date **Physician's Signature** **Phone #**

(Revised 11/14/18)