ARCHDIOCESE OF LOS ANGELES
MEDICATION AUTHORIZATION AND PERMISSION FORM

Part A, B & C to be completed by a licensed Physician
Part D by parent/guardian – *please print*

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. **To the Parent/Guardian:** The inhaler may be carried by the student and used as prescribed after this form has been filed with the school health office.

Permission for Medication to be Taken During School Hours

I request that my child, _____, be permitted to carry and use an inhaler at school during school hours as prescribed by his/her doctor. I will comply with the policies and procedures determined by the school district.

_____
Parent Signature

_____ _____ _____
Date Day Telephone Emergency Telephone

9/01/02