Medication Consent Form
Catholic Diocese of Jackson

Saint Anthony Catholic School

Student Name_____

Physician's Order for Prescription
Medication Administration

Name of Medication _____

Dosage _____

Times to be given _____

The physician must be notified immediately if the following conditions or circumstances arise in connection with the administration of this medication.

_____

Physician Signature_____

Date_____ Phone Number_____

Parent Request and Authorization

I authorize the school to administer the above medication and release the school/center and its employees from any liability in administering the above medication according to stated dosage and times.

_____

Parent Signature_____

Date_____

Request and Authorization
For Non-Prescription Medication
Catholic Diocese of Jackson

Saint Anthony Catholic School

Student Name_____

Non-Prescription Medication Administration

Name of Medication _____

Dosage _____

Times to be given _____

Parent Request and Authorization

I authorize the school to administer the above medication and release the school/center and its employees from any liability in administering the above medication according to stated dosage and times.

_____

Parent Signature_____

Date_____