Prescription Medication

Medication Consent Form

Catholic Diocese of Jackson

School: Annunciation Catholic School

Student Name: _____

Physician's Order for Prescription Medication Administration

Name of Medication: _____

Dosage: _____

Times to be given: _____

Physician must be notified immediately if the following conditions or circumstance arise in connection with the administration of this medication.

_____

_____

_____

_____

_____ _____

Physician's Signature **Date**

Physician Contact Number: _____

Parent Request and Authorization

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

_____ _____

Parent Signature **Date**