

Medication Consent Form
Catholic Diocese of Jackson
Non-Prescription Medication
Annunciation Catholic School

Student Name _____

Name of Medication _____

Dosage _____

Times to be given _____

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

Physician's Name _____

Phone Number _____

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