Diocese of Palm Beach
AUTHORIZATION FOR MEDICATION FORM

Saint John Paul II ACADEMY
Live By The Spirit Of Faith.

Student Name:	**Date:**

It is necessary that medication be given as follows:

Prescription Medication (Brand Name and name as it appears on container if different)	**Dosage** (Amount to be given)	**Form of Medication**	**Prescription No.**
		❐ Tablet ❐ Capsule ❐ Liquid ❐ Pill ❐ Inhalant ❐ Other: ❐ Color (if applicable):	
Dispensing Instructions (how often / what time):			

Prescription Medication (Brand Name and name as it appears on container if different)	**Dosage** (Amount to be given)	**Form of Medication**	**Prescription No.**
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Dispensing Instructions (how often / what time):			

No injection will be given, except in an extreme emergency, such as allergy to bee sting or the like.

The parent knows of this request and is in full agreement that the medication(s) will be supplied as needed. Should the student manifest any of the following symptoms caused by the medication(s), please contact the parent or my office.

Symptoms:

Known Allergies:

Physician's Signature:	Parent's Signature:
Print Physician's Name:	Print Parent's Name:
Physician's Phone Number:	Parent Phone Number: