MATER DEI HIGH SCHOOL

Medication Authorization Form

2024-25

Please complete the following information for any medication you would like the school to administer. Include the medication, how much should be given, and if there's a specific time to give. Prescription medication should be in a marked container that includes the physician's order and name of the medication. Over the counter medication should be provided in the original container.

STUDENT NAME: _____ ***DOB:*** _____ ***GRADE:*** _____

LIST MEDICATION / DOSAGE BELOW:

NAME OF MEDICATION: _____

DOSAGE & FREQUENCY: _____

DIAGNOSIS/PURPOSE: _____

NAME OF MEDICATION: _____

DOSAGE & FREQUENCY: _____

DIAGNOSIS/PURPOSE: _____

NAME OF MEDICATION: _____

DOSAGE & FREQUENCY: _____

DIAGNOSIS/PURPOSE: _____

NAME OF MEDICATION: _____

DOSAGE & FREQUENCY: _____

DIAGNOSIS/PURPOSE: _____

I request the enclosed medication, in the original container, be administered to my child and shall release school personnel from all liability.

Parent Signature: _____ **Date:** _____

THIS FORM IS ONLY VALID FOR THE CURRENT SCHOOL YEAR.