AUTHORIZATION FOR DISPENSING MEDICATION

Parent or Guardian

I request that my son/daughter _____ Grade _____, a student at St. Stanislaus School receive medication as prescribed by Dr. _____ in the form below. My child's date of birth is _____

The medicine is to be furnished by me as designated in the medication policy of the Diocese of Fall River, Department of Education.

I understand that the school is rendering a service and does not assume any responsibility in this matter.

Signature_____

Date _____ Phone #s _____

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Whenever possible, medication should be given at home and every effort made to avoid school hours.

Physician

I request that my patient receive the following medication:

Name of Pupil _____ (DOB) _____

Name of Medication _____ Diagnosis _____

Prescribed Dosage _____

Time and method to be taken during school hours _____
Expected duration of treatment _____
Possible side effects and adverse reactions _____
_____
Other recommendations _____

Signature_____

Date _____ Phone # _____