St. John the Apostle
Catholic School

Medication Dispensation Authorization

Parent/Guardian Authorization to Principal of St. John the Apostle Catholic School

Name of Child:_____DOB:_____

Name of Medication:_____

Dosage: _____Time to be given: _____

Medication to be taken until: _____

This medication was prescribed by: _____
(Doctor's first and last name)

Doctors Address:_____

_____

Doctor's phone number: _____

Purpose for medication: _____

Special Instructions: _____

_____

Potential Side Effects: _____

_____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

This authorization applies only to the medication listed above and for the duration of the therapy or school year. Use one form for **each** medication the child is on.