



PRESCRIPTION MEDICATION AUTHORIZATION FORM

NAME OF STUDENT:	DOB:
<input type="text"/>	<input type="text"/>
EVENT & LOCATION:	DATES:
<input type="text"/>	<input type="text"/>

Medications: List all prescription medications that the student currently takes during the day. Include all as-needed and emergency medications. Medications not authorized for self-carry must be in original container and given to the designated supervisor.

DAILY MEDICATIONS						
MEDICATION	DOSAGE:	HOW GIVEN:	FREQUENCY:	START DATE:	END DATE:	SIDE EFFECTS
<i>example: Sertraline</i>	<i>50 mg</i>	<i>Oral</i>	<i>Daily, Morning</i>	<i>11/07/26</i>	<i>11/08/26</i>	<i>Nausea, diarrhea, or decreased appetite</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

AS NEEDED OR PRN MEDICATION						
MEDICATION	DOSAGE:	HOW GIVEN:	FREQUENCY:	START DATE:	END DATE:	SIDE EFFECTS
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

MEDICAL PROVIDER CONSENT	
I authorize the parish/archdiocese to give the above medication(s) to this Student.	
Asthma Inhalers and an epinephrine auto-injector (i.e., EpiPen) Only: This student and his/her parents have been instructed in self-administration and the student may carry an inhaler or Epi-Pen and self-administer. ☐ YES ☐ NO	
PRINT MEDICAL PROVIDER NAME:	PHONE NUMBER:
<input type="text"/>	<input type="text"/>
MEDICAL PROVIDER SIGNATURE:	DATE:
<input type="text"/>	<input type="text"/>

PARENT/GUARDIAN CONSENT	
I give the parish/archdiocese to administer the above medications as directed by the medical provider. Parish/archdiocesan personnel may contact the medical provider and parent with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above.	
Inhaler/an epinephrine auto-injector (i.e., EpiPen) Only: My child may ☐ or may not ☐ carry and self administer.	
PARENT/GUARDIAN SIGNATURE:	DATE:
<input type="text"/>	<input type="text"/>