

**Medication Consent Form
Catholic Diocese of Jackson**

_____ **School**

Student Name _____

I

*Physician's Order For
Prescription Medication Administration*

Name of Medication _____

Dosage _____

Times to be given _____

The physician must be notified immediately if the following conditions or circumstances arise in connection with the administration of this medication.

Physician's Signature

Date

Phone Number _____

II

Parent Request and Authorization

I authorize the school to administer the above medication and release the school/center and its employees from any liability in administering the above medication according to stated dosage and times.

Parent Signature

Date