Cathedral Academy

Physician/Parent Medication Authorization Form
2024-2025 School Year

STUDENT'S NAME ______________________ DATE OF BIRTH ______________

AGE ________ SEX _______ GRADE ______ HOMEROOM ______________________

Medication ____________________________ Dosage ______________________________

Purpose of Medication ____

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Possible side effects ____

Anticipated number of days medication is to be given at school ______________________

Medications are dispensed at the nurse clinic in Building C.

_________________________ _________________________

Physician's Name *(please print)* Date

_________________________ _________________________

Physician's Signature Phone and Fax numbers

I hereby give my permission for ____________________ to take the above prescription at school as ordered. I understand that it is my responsibility of furnish this medication.

Date____________________ Signature of Parent/Guardian ___________________________

Parent's Emergency Number(s) ____

Parent's email(s) ____

Note:
The prescription medication is to be brought to school in a properly labeled pharmacy container only.

CA-F018

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