



CATHEDRAL ACADEMY

Physician/Parent Medication Authorization Form 2025-2026 School Year

STUDENT'S NAME _____ DATE OF BIRTH _____
AGE _____ SEX _____ GRADE _____ HOMEROOM _____

Medication _____ Dosage _____

Purpose of Medication _____

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 to 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.