



***Our Lady of the Angels School***

404 Cherry Street, Columbia, PA 17512

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*www.ourladyoftheangels.org*

**Authorization for PRESCRIPTION Medication**

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

In accordance with Diocesan policy #4108 all prescription medication must be in the original properly labeled container. The container should be "child-proof" and labeled by a pharmacist or a physician. The original container is to be accompanied by this completed form.

Name of physician prescribing the medication: \_\_\_\_\_

Name of the medication: \_\_\_\_\_

Physician's Directions:

- a. Amount to be given: \_\_\_\_\_
- b. Time to be given: \_\_\_\_\_
- c. Date(s) to be given: \_\_\_\_\_
- d. Reason: \_\_\_\_\_

Curtailment of specific school activities (if any): \_\_\_\_\_

Other medications which the student is taking: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_