ST. EDWARD CENTRAL CATHOLIC HIGH SCHOOL
MEDICATION AUTHORIZATIONFORM

DATE: _____ **CLASS OF:** _____

STUDENT'S NAME: _____
Last **First** **Middle Initial**

The parent must complete the top half of the form before any medication may be administered.
The student will complete the section titled, "OFFICE USE," and office staff will initial each time the student takes the medication at school.
Physicians orders/prescriptions must be attached to this form.

I hereby authorize St. Edward High School to supervise my child taking the following medication and release all school personnel I volunteers from claims arising from the administration of the medication.

_____ _____
Parent/Guardian Signature Parent/Guardian Name Printed

Doctor's Name: _____

Prescription: _____ Dosage: _____

Prescription: _____ Dosage: _____

Prescription: _____ Dosage: _____

Over the counter medication: _____ Dosage: _____

Over the counter medication: _____ Dosage: _____

OFFICE USE

Date	Time Taken	Student Initials	Staff Initials

Date	Time Taken	Student Initials	Staff Initials

OFFICE USE

Date	Time Taken	Student Initials	Staff Initials

Date	Time Taken	Student Initials	Staff Initials