MEDICATION PERMISSION FORM

Student _____ Grade _____

Birth Date _____School _____

Name of Family _____

Home Address _____

Home Telephone _____ Work Telephone _____

REQUEST AND AUTHORIZATION

I hereby declare that it is not possible to make arrangements for the parent/guardian to administer required medication to my student therefore request and authorize the school administration of the following prescribed medication for my child

_____

by non-medically trained staff at

St Francis de Sales School, Oak Park.

(Parents are required to bring the properly labelled medication in its original container)

Date _____ Signature _____

Name of student's physician _____

Telephone _____

In emergency, please contact: _____

Telephone _____

SIGNATURE OF PARENT _____