ST. RAPHAEL SCHOOL MEDICATION PERMISSION FORM

Student's Name____Birthdate:_________

Address:____Phone Number:_________

School:________________________Grade:_________________

Emergency Number:_____________________________

I hereby grant permission for the above named school to issue the medication routine described below for the above named child.

Parent's Signature:___________________________________Date:_________________

To be completed by the physician:

Name of Medication:____

Dosage:____Time:________________

Type of Disease or Illness:____

Is this medication necessary in order to maintain the child at school? ________________

Side effects to be alert to: ____

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Doctor's Signature: __________________________________Date:_________________

Emergency Number: _________________________________

Further Instructional Remarks: ____

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