

Department of Catholic Schools

Archdiocese of San Antonio 2718 W. Woodlawn Ave San Antonio, Texas 78228 (210) 734-2620 • Fax (210) 734-9112 www.sacatholicschools.org

MEDICATION PERMISSION REQUEST FORM

Please fax form	to		at fax number		
	School Na	me			
including non-prescrip and self-administer in administration of medi	tion medications. (The haler medication). Cations at school. Therse drug reactions a	ne only exception The principal will the medication ma and side effects of	is that, by physici l designate a res y be administered properly adminis	ot allowed to carry medic an direction, a student ma ponsible person to super by non-medical personne tered medication. The followed	by be allowed to carry rvise the storing and al. The school will be
2. Parent/gua pharmacist		e medication in to. Medication may	he original prescr	ool iption bottle, properly la ol personnel provided that	
Name of student:				Grade:	
Date of Birth:		School:			
******			**************************************	**************************************	*****
Medication #1Name		Strength	Dose	Time (at school)	Route
Medication #2		Suchgui	2000	Time (at sensor)	route
Name Name		Strength	Dose	Time (at school)	Route
Medication #3 Name					
		Strength	Dose	Time (at school)	Route
Allergies:					
Special Instructions:					
Printed Name of Health Care Provider:		Signature of Health Care Provider:			Date:
*******	*******	******	*******	*********	*******
		TO BE COMPL	ETED BY PAREN	NT	
I,Printed Name pare	, request that nt/guardian	my child be given	the above medicat	tion as directed.	

Signature of Parent/guardian: _______Date: ______

Telephone: (Home) _____ (Work) ____ (Mobile) ____