Medication Consent Form
Catholic Diocese of Jackson

Cathedral School

Student Name _____

Physician's Order For
Prescription Medication Administration

Name of Medication _____

Dosage _____

Times to be given _____

The physician must be notified immediately if the following conditions or circumstances arise in connection with the administration of this medication.

Physician's Signature_____ Date _____

Parent Request and Authorization

I authorize the school to administer the above medication and release the school/center and its employees from any liability in administering this non-prescription medication according to the stated dosage and times.

Parent's Signature_____ Date _____