



# RHODORA J. DONAHUE ACADEMY OF AVE MARIA

4955 Seton Way, Ave Maria, FL 34142

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## Medication Authorization and Permission

Student Name: \_\_\_\_\_ Sex: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Purpose of medication or diagnosis: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Dosage prescribed: \_\_\_\_\_

Time schedule at school: \_\_\_\_\_

Dose form—liquid/tablet (color): \_\_\_\_\_

Date of prescription: \_\_\_\_\_ Dates to be taken: from \_\_\_\_\_ to \_\_\_\_\_

Any adverse effects the medication may have:

\_\_\_\_\_  
\_\_\_\_\_

Special instructions and/or comments: \_\_\_\_\_

Name of physician: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Permission for Medication to be Taken During School Hours

I request that my child be permitted to receive and to be assisted/supervised in taking the above prescribed medication at school. I will comply with the policies and procedures determined by the school.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

I request that my child be allowed to carry lifesaving medication on his person at all times.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Day Telephone: \_\_\_\_\_ Emergency Telephone: \_\_\_\_\_