Diocese of Palm Beach

Medication Form for 2024-2025 School Year

Date: _____

Student Name: _____
(please print legibly)

It is necessary that medication be given as follows:

Name of medication: _____
(Brand Name. Also, Medication Name as it appears on container (if generic equivalent)

Prescription No.: _____

Color, if applicable: _____

Please circle form of medication:

Tablet Pill Capsule Inhalation Liquid Other/Specify: _____

Dosage: _____ How often/What time given: _____
**NO injections will be given, except in an extreme emergency, such as allergy to bee sting or the like.

The parent knows of this request and is in full agreement that this medication will be supplied as needed. Should the student manifest any of the following symptoms caused by the medication, please contact the parent or my office.

Remarks: _____.

Known allergies: _____
_____.

_____ _____
Print Parent Name Parent Signature

Please print Physicians name: _____

_____ _____
Physicians Signature Physicians Phone Number