Mater Dei High School
2021-2022 School Year
MEDICATION AUTHORIZATION FORM

Name of Student: ____ DOB: _________

Grade/Team/Graduation Year: ____

Name of Medication: ____

Dosage and frequency: ____

Diagnosis/Purpose: ____

Name of Medication: ____

Dosage and frequency: ____

Diagnosis/Purpose: ____

Name of Medication: ____

Dosage and frequency: ____

Diagnosis/Purpose: ____

Name of Medication: ____

Dosage and frequency: ____

Diagnosis/Purpose: ____

I request the enclosed medication, in the original container be administered to my child and shall release school personnel from all liability.

Parent's Signature: ____ Date: __________

Primary Phone Number: ____

Secondary Phone Number: ____

THIS FORM IS ONLY VALID FOR THE CURRENT SCHOOL YEAR

Revised 7/2021