MONSIGNOR DONOVAN
CATHOLIC HIGH SCHOOL

PRESCRIPTION MEDICATION CONSENT

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 Phone Number Date

PARENT REQUEST AND AUTHORIZATION

I authorize the school to administer the above medication and release Monsignor Donovan Catholic High School and its employees from any liability in administering the above medication according to the stated dosage and times.

_____ _____

Parent Signature Date