Central Catholic Jr/Sr High School
Student Prescribed/Alternative Medication Permission Form

Date received by school: ___________

Student: ____ Date of birth (age): ____________________

School Year: _____________ Grade: ______________

TO BE COMPLETED BY PARENT OR AUTHORIZED PRESCRIBER

Reasons for medication: ____

Name of medication: ____

Form of medication/treatment:

- □ Tablet / Capsule
- □ Liquid
- □ Inhaler
- □ Injection
- □ Other: ____

Instruction (list specific times dosage given at school): ____
____

Start Date: ____________________________ Stop date: ___________________________________

□ For episodic / emergency events only

□ Yes, there are special requirements:
□ Refrigerate □ Other: ____

□ Student may carry this medication for self-administering: □ Yes □ No

Please indicate if you have provided additional information, either □ on back of this form or □ as an attachment.

TO BE COMPLETED BY PARENT/GUARDIAN: I give permission for (name of child) ______________________________ to receive the above medication at the school according to standard school policy. **Medication must be brought in the <u>original</u> container.**

Signature: ____ Date: ___________________